Province of British Columbia
Ministry of Health and
Ministry Responsible for Seniors
DIVISION OF VITAL STATISTICS

REGISTRATION OF DEATH

DOCUMENT CONTROL NUMBER (Office Use Only): 100680891

REGISTRATION NUMBER (Office Use Only): 96-024821

THIS IS A PERMANENT LEGAL RECORD - TYPE OR PRINT PLAINLY - COMPLETE ALL ITEMS
DO NOT USE RED OR GREEN INK
(See reverse for legal requirements under the Vital Statistics Act)
IMPORTANT: Any change or correction made in the completion of this form must be initialled by the person certifying the original information

NAME OF DECEASED

1. SURNAME (Print or Type): KEAN
ALL GIVEN NAMES (Print or Type): JUNE SHIRLEY

2. SEX: [ ] M [X] F [ ] U/K

3. DATE OF DEATH (By Name): MONTH Dec DAY 14 YEAR 1996

PLACE OF DEATH

4. NAME OF HOSPITAL OR INSTITUTION (Otherwise give exact location where death occurred, address): River Road
CITY, TOWN OR OTHER PLACE (by name): Keremeos

RESIDENCY INFORMATION AND USUAL ADDRESS

B.C. RESIDENT [X] NON-RESIDENT [ ]

IF B.C. RESIDENT, PERSONAL HEALTH NUMBER: 9 0 6 2 0 3 7 9 3 4

5. ABORIGINAL STATUS? YES [ ] NO [X]
REGISTRATION #

6. COMPLETE STREET ADDRESS If rural give exact location (Not Post Office or Rural Route address): River Road

YEARS PRESENT IN COMMUNITY

CITY, TOWN OR OTHER PLACE (by name): Keremeos

PROVINCE/STATE (country): B. C.

POSTAL CODE: V 0 X 1 N 0

MARITAL STATUS

7. STATE
[ ] NEVER MARRIED [ ] MARRIED [ ] DIVORCED
[ ] SEPARATED [ ] WIDOWED [X] OTHER

8. IF MARRIED, WIDOWED, SEPARATED OR DIVORCED GIVE FULL NAME OF HUSBAND OR FULL MAIDEN NAME: Arthur Uren

OCCUPATION

9. KIND OF WORK: Homemaker
YEARS:

10. KIND OF BUSINESS OR INDUSTRY IN WHICH WORKED: At Home

BIRTHDATE

11. MONTH (by name) May DAY 19 YEAR 1930

12. AGE (YEARS) 66
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 1 DAY HOURS MINUTES

BIRTHPLACE

13. CITY, TOWN OR OTHER PLACE: North Battleford
PROVINCE/STATE (country) OF BIRTH: Saskatchewan

FATHER

14. SURNAME AND GIVEN NAMES OF FATHER (Print or Type): Freimark, Otto

15. BIRTHPLACE - CITY OR PLACE, PROVINCE/STATE (country): U.S.A.

MOTHER

16. MAIDEN SURNAME AND GIVEN NAMES OF MOTHER (Print or Type): Brown, Bessie

17. BIRTHPLACE - CITY OR PLACE, PROVINCE/STATE (country): Canada

INFORMANT

SIGNATURE: X Muriel Huddlestone
DATE SIGNED Month (By Name) Dec Day 15 Year 1996
RELATIONSHIP TO DECEASED: Sister

NAME OF INFORMANT (Print or Type): Muriel Huddlestone
ADDRESS OF INFORMANT: 13212 Henry St., Summerland, B.C.
POSTAL CODE: V 0 H 1 Z 0

TO BE COMPLETED BY FUNERAL DIRECTOR ONLY

DISPOSITION

18. TYPE OF DISPOSITION
[ ] BURIAL [X] CREMATION [ ] OTHER (SPECIFY):

19. BURIAL PERMIT NUMBER: 450699916

20. DATE OF BURIAL / DISPOSITION (By Name) Dec 16 1996

NAME AND ADDRESS OF CEMETERY, CREMATORIUM OR PLACE OF DISPOSITION: Pacific Crematorium, 1130 Carmi Ave., Penticton, B.C.

FUNERAL DIRECTOR

NAME OF FUNERAL DIRECTOR OR PERSON IN CHARGE OF REMAINS (Print or Type): Personal Alternative Funeral Services
CLIENT NO. 835

ADDRESS: 1130 Carmi Ave., Penticton, B.C.
POSTAL CODE: V 2 A 3 H 2

DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY

NOTATIONS

CERTIFICATION OF DISTRICT REGISTRAR

I CERTIFY THAT THIS RETURN ~~WAS ACCEPTED~~ BY ME ON THIS DATE AT: Penticton BRITISH COLUMBIA

Month (By Name) Dec Day 15 Year 1996

SIGNATURE OF DISTRICT REGISTRAR: W Edwardson

REGISTRATION DISTRICT No. 835

HLTH 406 REV 92/12
IBF 99251

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DOCUMENT CONTROL NUMBER (Office Use Only) 200241123

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PHYSICIAN'S

MEDICAL CERTIFICATION OF DEATH

This is a permanent legal record – Type or print plainly – Complete all items – Use blue or black ink only

See Reverse for Instructions

Important Notice to Doctors

Issue the Medical Certification of Death promptly to avoid delaying funeral arrangements. If the medical practitioner is for any reason unable to complete the Medical Certificate within 48 hours of death, the funeral director or the physician shall notify a coroner.

Name of Deceased

1. Surname (Print or Type): ~~UREN~~ KEAN
2. Sex: ☐ M ☑ F ☐ U/K
All given names: JUNE SHIRLEY
Personal Health Number: 9062 037 934

Actual Date of Death

3. Month (By Name) Day Year: DEC 04 1996
Approximate Time of Death (24 hour clock): 0920

Date of Birth

4. Month (By Name) Day Year: MAY 19 1930
If under 1 day: Hours ____ Minutes ____

Place of Death

5. Name of Hospital or Institution (Otherwise give exact location where death occurred, eg address): RIVER ROAD
City, town or other place (by name): KEREMEOS
Postal code: V0X 1N0
Type of place (e g Hospital, Nursing home, Home, Street, Workplace etc): HOME

MEDICAL CAUSE OF DEATH

SHADED AREA - OFFICE USE ONLY

		Approximate Interval Between Onset/Death
PART I Immediate cause of death	(a) CARCINOMA RECTUM	2 YRS
	due to, or as a consequence of	
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying causes last.	(b)	
	due to, or as a consequence of	
	(c)	
PART II Other significant conditions contributing to the death	DIABETES MELLITUS	10 YRS

I /
II*

Place of accident or violence. | Reject.

Other Medical Particulars

6. Recent surgery (28 days or less prior to death) ☐ Yes ☑ No
If Yes, date ____
Surgery & Findings ____

7. Coronary bypass ☐ Yes ☑ No
Heart valve replaced ☐ Yes ☑ No
Organ transplant recipient ☐ Yes (specify) ____ ☐ No

8. Was deceased pregnant at time of death? ☐ Yes ☑ No
OR
Did death occur within 90 days postpartum? ☐ Yes ☑ No

9. Environmental/occupational/ lifestyle (e g pesticides, asbestos, abuse of tobacco, alcohol etc) ☐ Yes (Specify below) ____ ☐ No ☑ Unknown

Autopsy Particulars

10. Autopsy being held? ☐ Yes ☑ No

11. Does cause of death stated above take account of autopsy findings? ☐ Yes ☑ No

12. May further information relating to cause of death be available later? ☐ Yes ☑ No

Manner of Death

13. State if death was ☑ Natural ☐ Accident ☐ Suicide ☐ Could not be determined ☐ Homicide ☐ Pending investigation
If death was NOT from natural causes was the Coroner notified? ☐ Yes ☐ No

Accident or Violence *(if applicable)*

14. Place of injury (exact location and type of place)

15. Date of injury Month (By Name) Day Year

16. How did injury occur? (describe circumstances)

Certification by Physician

I viewed the body after death ☑ Yes ☐ No

I attended the deceased for the final illness on: Month (By Name) Day Year: DEC 03 1996

I certify to the best of my knowledge and belief this person died on the date and from the cause(s) stated herein

Signature of medical practitioner X: Jeanes

Date signed: Month (By Name) Day Year: DEC 04 1996

Name of medical practitioner (print or type): MICHAEL R. JEANES

MSC Personal No, Phone No: 03560499 5518

Address: Box 219 KEREMEOS BC

Postal code: V0X 1N0

Notations *(Office use only)*

Certification of District Registrar

I certify that this was accepted by me on this date at: Penticton

Month (By Name) Day Year: DEC 9 1996

Signature of District Registrar: M. Cieredin

Registration District Number: 535

IMPORTANT: Any change or correction made in the completion of this form must be initialled by the person certifying the original information

HLTH 406A REV 92/12
IBF 85907