

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

25  
7733

APR 25 1927

**1. PLACE OF DEATH**

County Laclede  
Township Herculane  
City St. Louis (No. 5-104-B)

Registration District No. 286  
Primary Registration District No. 4192

File No. 7733  
Registered No. 5-104-B St. 104 Ward 104

**2. FULL NAME**

Pearl May Kenna  
(a) Residence. No. 104 St. 104 Ward 104  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF X

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24 1921

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
2 2 0 0

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work —  
(b) General nature of industry, business, or establishment in which employed (or employer) —  
(c) Name of employer —

9. BIRTHPLACE (CITY OR TOWN) MO  
(STATE OR COUNTRY)

10. NAME OF FATHER Oliver Kenna

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Miss  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Rosalie King  
(STATE OR COUNTRY)

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Miss  
(STATE OR COUNTRY)

14. INFORMANT Oliver Kenna  
(Address) Herculane MO

15. FILED Mo. 27 27 C. L. Speise  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 24 1927

17. I HEREBY CERTIFY, That I attended deceased from 11:00 a.m. to 1:00 p.m., 1927, and that death occurred, on the date stated above, at 1 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
accidentally suffocated  
while sleep in bed

CONTRIBUTORY (SECONDARY) 180  
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED MO  
IF NOT AT PLACE OF RESIDENCE

DID AN OPERATION PRECEDE DEATH? NO DATE OF —  
WAS THERE AN AUTOPSY? Cor. View

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. J. Kingdon, M. D.  
(Address) Kenna at no

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Pine City Cem  
DATE OF BURIAL 3-24-1927

20. UNDERTAKER Home used coffin  
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. This the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Dunklin  
Township Polcomb  
City Polcomb (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 286  
Primary Registration District No. 32404 B

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Paul May Kenaman  
(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 24, 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 2

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Elmer Kenaman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Ada T. King

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri  
(STATE OR COUNTRY)

14. INFORMANT Elmer Kenaman  
(Address) Polcomb mo

15. FILED 5-13-1927 J. A. Anderson  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 24 1927

17. unattended by doctor  
I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_  
1-a-m

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

accidentally suffocated while asleep in bed

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no - view  
WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. J. Rigdon, M. D.  
, 19\_\_\_\_ (Address) Kennett mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Pine City cem DATE OF BURIAL 3-14-1927

20. UNDERTAKER Home Made Coffin ADDRESS 2

**SUPPLEMENTARY**

PHYSICIAN'S NAME AND ADDRESS: \_\_\_\_\_  
REGIS. RS. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
Physician's Name and Address: \_\_\_\_\_  
Physician's Signature: \_\_\_\_\_  
Physician's Title: \_\_\_\_\_  
Physician's License No.: \_\_\_\_\_  
Physician's State: \_\_\_\_\_  
Physician's Date of Issue: \_\_\_\_\_  
Physician's Date of Expiration: \_\_\_\_\_  
Physician's Date of Renewal: \_\_\_\_\_  
Physician's Date of Revocation: \_\_\_\_\_  
Physician's Date of Suspension: \_\_\_\_\_  
Physician's Date of Reinstatement: \_\_\_\_\_  
Physician's Date of Annulment: \_\_\_\_\_  
Physician's Date of Resignation: \_\_\_\_\_  
Physician's Date of Death: \_\_\_\_\_  
Physician's Date of Retirement: \_\_\_\_\_  
Physician's Date of Other: \_\_\_\_\_

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