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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 23227

Township ..... Primary Registration District No. ..... Registered No. 6700

City St. Louis St. Johns Hospital ..... St. ..... Ward)

2. FULL NAME James Edward Kennard

(a) Residence. No. 2521 Arden ave St. 12 Ward. Pine Lawn Mo
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 4 1917

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	12		19	

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) Woodstock ~~Minn~~
(STATE OR COUNTRY) Minnesota

PARENTS

10. NAME OF FATHER Thomas J Kennard

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

12. MAIDEN NAME OF MOTHER Mary Thoma

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

14. INFORMANT Thomas J. Kennard, Jr.
(Address) 2515 Arden ave

15. FILED JUL 31 1929 Max C Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 23 1929

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to June 23, 1929 that I last saw him alive on June 23, 1929, and that death occurred, on the date stated above, at 3 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicaemia general following infection of upper lip from picking a cold sore
21 (duration) ..... yrs. ..... mos. ..... ds.

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
WHAT TEST CONFIRMED DIAGNOSIS? Lab. tests
(Signed) Robt Hyland, M. D
6-24, 1929 (Address) 3901 Park

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calvary Cemetery
DATE OF BURIAL: June 25th 1929

20. UNDERTAKER: Tanner and Morgan
ADDRESS: 6107 Natural Bridge Rd

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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