

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

Do not use this space.

41407

File No. 14
Registered No. _____
St. _____ Ward)

PLACE OF DEATH
County Marion Registration District No. 032
Township Warren Primary Registration District No. 3743
City _____ (No. _____ St. _____ Ward)

2. FULL NAME David C. Kenney
(a) Residence No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1st 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 9 28

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

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

10. NAME OF FATHER David C. Kenney

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

12. MAIDEN NAME OF MOTHER Compass

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

14. INFORMANT Genevieve Kenney
(Address) Warren mo

15. FILED 1/8 1930 Rosa E. Wagner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 29th 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1929, to Dec. 29, 1929, that I last saw him alive on Dec. 28, 1929, and that death occurred, on the date stated above, at 5:08 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus with accompanying Nephritis

198 (duration) chronic yrs. mos. ds.
CONTRIBUTORY Senility
(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
(Signed) Dr. S. J. Adress, M. D.

, 19 (Address) Philadelphia 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Warren Cemetery
Warren mo DATE OF BURIAL Dec. 31 1929

20. UNDERTAKER Wilson & Son ADDRESS Monroe City mo

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

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

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