

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

Do not use this space.

19625

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. 4408 Rockhill Road St. _____ Ward)

File No. _____
 Registered No. 2526

2. FULL NAME John C. Fennell

(a) Residence. No. 4408 Rockhill Road St. _____ Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 22, 1857

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
72 11 2

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Dunkirk (STATE OR COUNTRY) New York

10. NAME OF FATHER Wm. H. Fennell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) not known

14. INFORMANT Mrs. J. C. Fennell (Address) 4408 Rockhill Road

15. FILED 7/24/30 M. M. Kerwin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 24 1930

17. I HEREBY CERTIFY, That I attended deceased from 14 July of June, 1930, to 24 June, 1930, that I last saw him alive on June 24, 1930, and that death occurred, on the date stated above, at 8:40 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypopneumonia (Broncho pneumonia)
107A

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Diabetes frangens
 (duration) yrs. 3 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS medical clinical

(Signed) H. O. Clure M.D.

6/24/30 (Address) 4024 Oakman St.

*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 not Washington Cem DATE OF BURIAL 6/26 1930

20. UNDERTAKER Stein & M. Clure ADDRESS 3235

Billham Plaza

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.

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