

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

Do not use this space.

23946

**1. PLACE OF DEATH**

County Ralls Registration District No. 725  
Township Gasper Primary Registration District No. 5960.C  
City (No. ....) St. .... Ward)

File No. ....  
Registered No. ....

**2. FULL NAME**

Silvanus Kennedy

(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 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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11 - 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
70 8 3

**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) Warren Co  
(STATE OR COUNTRY)

10. NAME OF FATHER Tom Kennedy

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

12. MAIDEN NAME OF MOTHER Melary Gibson

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

14. INFORMANT Gene Kennedy  
(Address) Custer Mo

15. FILED 7-9-30 1930 J. J. Howard REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 7 1930

17. HEREBY CERTIFY, That I attended deceased from July 5, 1930, to July 5, 1930, (that I last saw him alive on July 5, 1930, and that death occurred, on the date stated above, at between 1-7 P.M.)

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Ischemic  
131  
92A  
97 (duration) not known yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arterio-Sclerosis & Calculus Heart (duration) not known 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 Arteriosclerosis etc  
(Signed) W. H. Balth M. D.

July 8, 1930 (Address) Custer, 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 Salome Burial DATE OF BURIAL July 8 1930

20. UNDERTAKER W. H. Couch ADDRESS Custer

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. AUG 26 1930 69-7-1-26

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**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 Calla Registration District No. 725- File No. ....  
Township Jasper Primary Registration District No. 5960 Registered No. ....  
City (No. ....) St. .... Ward)

**2. FULL NAME**

Sylvanna Kennedy  
(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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-11-1860

7. AGE YEARS 69 MONTHS 7 DAYS 26 If LESS than 1 day, .... hrs. or .... min.

**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) .....  
(STATE OR COUNTRY) .....

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

**14.**

INFORMANT .....  
(Address) .....

**15.**

FILED Sept 20 1920 J. J. Howard REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 7 1930

17. I HEREBY CERTIFY That I attended deceased from .....  
....., 19..... to .....  
that I last saw h..... alive on .....  
death occurred, on the date stated above, at .....

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

.....  
..... (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? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ..... M. D.  
, 19 (Address)

\*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**

**DATE OF BURIAL**

..... 19

**20. UNDERTAKER**

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

**SUPPLEMENTARY**

S-23946