OCT 29 1930

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

Do not use this space.

30329

1. PLACE OF DEATH
County Johnson
Township Rose Hill
City ..... (N. ..... St. ..... Ward)
Registration District No. 437
Primary Registration District No. 5594
File No. .....
Registered No. .....

2. FULL NAME James Preston 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 50 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) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 10-1860

7. AGE

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

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) (STATE OR COUNTRY) Missouri

PARENTS
X 10. NAME OF FATHER William Kennedy
X 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
X 12. MAIDEN NAME OF MOTHER Martha White
X 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Do not know

14. X INFORMANT T. P. Kennedy
(Address) Kingsville Mo.

15. FILED Oct 8 1930 Dr. J. F. Sheffer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 10 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 9:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: appoplexy died instantly

82 A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 74 A (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. F. Sheffer, M. D.
, 19 (Address) La Tour, Missouri

*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 Hornsby Cemetery
DATE OF BURIAL Sept 12 1930

20. UNDERTAKER W. Goodman
ADDRESS Holden Mo.

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.