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

Do not use this space.

41098

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....

Township..... Primary Registration District No. 1003 Registered No. 11761

City..... (No. City Hospital St. ..... Ward)

2. FULL NAME Timothy Kennedy

(a) Residence. No. 7203a S. Broadway St. 1 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14-1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.
	63	10	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 1148 10M

(b) General nature of industry, business, or establishment in which employed (or employer) Day

(c) Name of employer

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

PARENTS

10. NAME OF FATHER James Kennedy

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Dan Kennedy
(Address) 7203a S. Broadway

15. FILED DEC 16 1930, 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 14 1930

17. No Physician in Attendance

I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 5A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Haemorrhage into Left Lung Fractured Femur Struck by Auto while Attempting to Cross Street

CONTRIBUTORY (SECONDARY) Was pedestrian Criminal Carelessness (duration) ..... yrs. ..... mos. ..... ds.

In St. Louis Mo

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH 1880

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Kerner, M.D.

12/15, 1930 (Address) Dep. Coroner

*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
Calvary	12-17 1930
20. UNDERTAKER	ADDRESS 6320
Southern	S. Grand Blvd

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.