

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

Do not use this space.

1221

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kaw Primary Registration District No. _____
City Kansas City (No. 3815 Terrace)

File No. _____
Registered No. 52
St. _____ Ward _____

2. FULL NAME John Kennedy

(a) Residence. No. 3815 Terrace St. 5 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 (OR) WIFE OF Mrs. Sarah Kennedy

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
65 9 2 unk

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman 1820
(b) General nature of industry, business, or establishment in which employed (or employer) Pinkerton Det Agency
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ireland 15

10. NAME OF FATHER Owen Kennedy

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

12. MAIDEN NAME OF MOTHER Ann Cox

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

14. INFORMANT Mrs. Sarah Kennedy
(Address) 3815 Terrace

15. FILED Jan 5 1931 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1931 1931

17. I HEREBY CERTIFY, That I attended deceased from 1-1-30 1930, to 1-5-30 1930, that I last saw him alive on 1-4-30 1930, and that death occurred, on the date stated above, at 7:50 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
(duration) yrs. mos. ds. 9 2 1

CONTRIBUTORY (SECONDARY) arterio sclerosis
(duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED USA

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical path
(Signed) J. P. [Signature] M. D.

1-5-1930 (Address) 410 [Address]
*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Marys DATE OF BURIAL 1/7/31 1931

20. UNDERTAKER Quirk & Tobin--20 W Linwood ADDRESS _____

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. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

