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.

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

1661
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City Kansas City
(d) Street No. North east Hosp St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 399
Primary Registration District No. 1007
Registered No. 349

2. PRINT FULL NAME Mrs. Millie Kennedy 580
(a) Residence, No. Northeast Hospital, K. C. Mo. St. Lexington Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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 Kelsaw Kennedy

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-1-1910

7. AGE: Years 27 Months 7 Days 22 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housw
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) 0
(STATE OR COUNTRY) Mo 0

FATHER
13. NAME Albert Greer 0
14. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME Barbara Cartmell
16. BIRTHPLACE (CITY OR TOWN) Independence
(STATE OR COUNTRY) Mo

17. INFORMANT Kelsaw Kennedy
(ADDRESS) Lexington Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Lexington Mo DATE Jan 25 1938

19. FUNERAL DIRECTOR Mr. C. L. Foster
(ADDRESS) 914 Broadway

20. FILED 1/25 1938 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 23rd 1938

22. I HEREBY CERTIFY, That I attended deceased from 1-18th 1938, to 1-23rd, 1938, 19..
I last saw her alive on 1-23rd-38, 19.... Death is said to have occurred on the date stated above, at 6:00 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Myocarditis	
147	

Other contributory causes of importance:
Toxemia of pregnancy

Name of operation Cesarean section Date of 1/19/38
What test confirmed diagnosis? X ray Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19..
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) [illegible] M. D.
(Address) Lexington, Missouri

(Licensed Embalmer's Statement on Reverse Side)

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MO. STATE BOARD OF HEALTH

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)