

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.

NOV 16 1938

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

34162
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Mo. Registration District No. 791
(b) Township St. Louis Mo. Primary Registration District No. 1003
(c) City St. Louis Mo. (d) Street No. 3207 Lucas, St. Registered No. 9148
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Stacia Kennedy

(a) Residence, No. 3207 Lucas, St. St. 21 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF, OR (OR) WIFE OF Ciscero Kennedy
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 31~~st~~ 1904
7. AGE YEARS 34 MONTHS 2 DAYS 11 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) (STATE OR COUNTRY) Starkville, Miss.

FATHER 13. NAME Wiley Halfacer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Georgie

MOTHER 15. MAIDEN NAME Pallee Thomas

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Starkville, Miss.

17. INFORMANT (ADDRESS) Ciscero Kennedy 3207 Lucas, St.

18. BURIAL, CREMATION, OR REMOVAL By Rail
PLACE Artesia, Miss. DATE Oct. 21, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. L. Beal 2726 Lucas, St.

20. FILED Oct 21 1938 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

No physician in attendance
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/14/38, 19
22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
I last saw h_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 2:45 A.M.
The principal cause of death and related causes of importance were as follows:

Chronic Degenerative Myocarditis
Other contributory causes of importance:
Date of onset

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? Yes

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? No
If so, specify _____
(Signed) Joseph L. McGuinn
(Address) Deputy Coroner

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by *Cassius W. Penellita*

Registered Apprentice No. *125*....., working under my personal supervision.

Signed

Birdie Beal Anderson

Licensed Embalmer No.

2929

P. O. Address

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

If this body is not embalmed, above space should be left blank.