

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

Do not use this space.

REC'D JAN 9 1939

1. PLACE OF DEATH

County St Francois Registration District No. 224  
Township St Francois Primary Registration District No. 4465  
City Flat River (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 44381  
Registered No. 835

2. FULL NAME: Robt Joshua Kennedy

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 12 1881

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, 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) S

13. NAME Carol Kennedy

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fredericktown Mo

15. MAIDEN NAME Witzger Catherine Kennedy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jeff City Mo

17. INFORMANT (ADDRESS) Mary Kennedy Flat River Mo

18. BURIAL, CREMATION, OR REMOVAL Wood Lawn DATE 12 21 1938

19. UNDERTAKER (ADDRESS) Caldwell Bros Flat River Mo

20. FILED 1/4 1939 OB Ferrer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 19 1938

22. I HEREBY CERTIFY, That I attended deceased from June 9 1938, to 12-19-38, 1938

I last saw him alive on 12-18 1938. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Chc myocarditis & decompensation Date of onset \_\_\_\_\_

Other contributory causes of importance: 930

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Exam Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accutent, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1938

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 \_\_\_\_\_

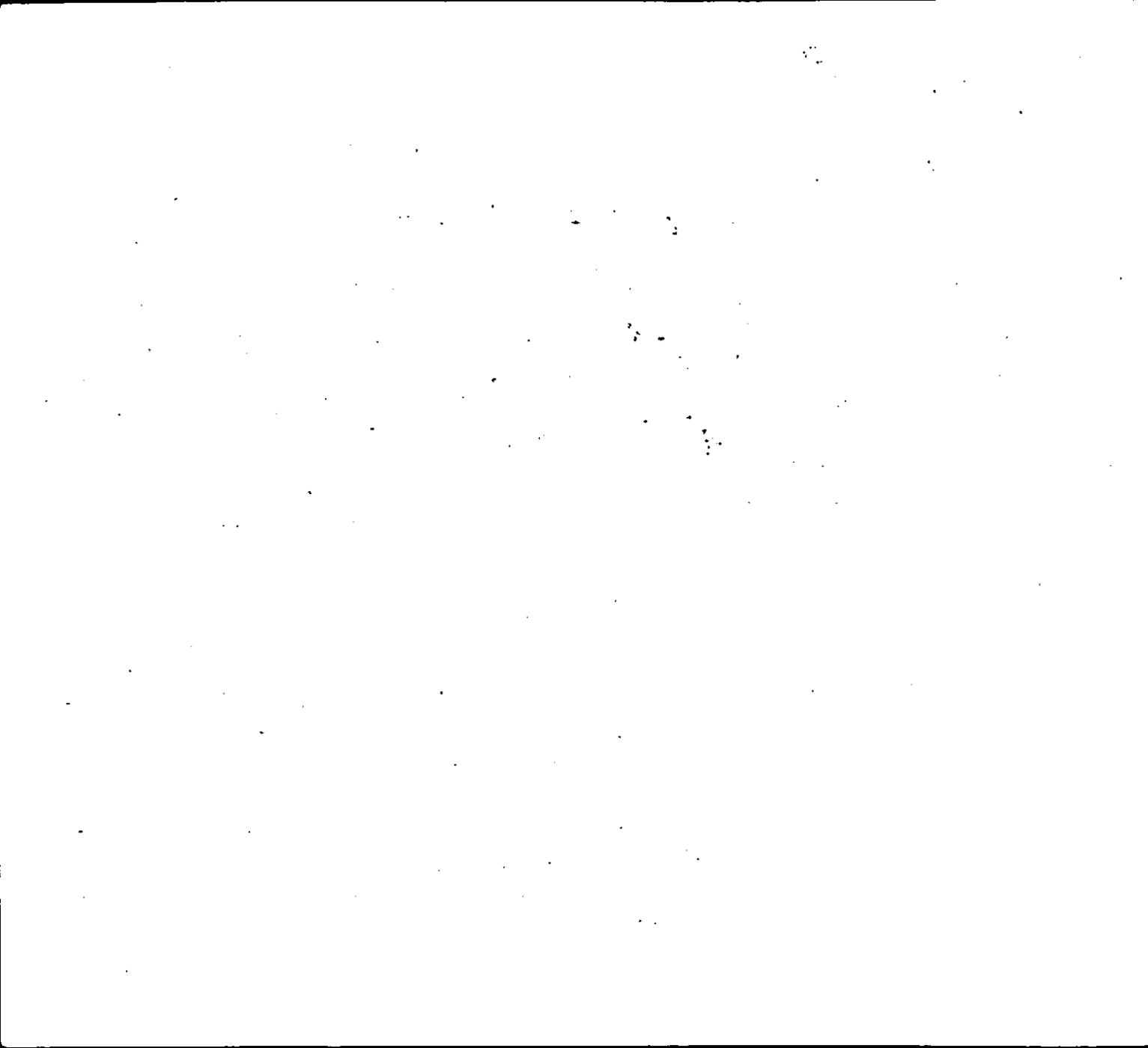
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) C H Gubbery, M. D.

1.7 (Address) Flat River Mo



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

44381  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 774

(b) Township \_\_\_\_\_ Primary Registration District No. 4465

(c) City Flat River (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_

(e) Length of residence in city or town where death occurred \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number)

(f) How long in U. S., if of foreign birth? yrs. mos. ds. \_\_\_\_\_

2. PRINT FULL NAME Robt. Joshua Kennedy

(a) Residence, No. \_\_\_\_\_ St.  (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-12-1881

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

57 2 7

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Paper Hanger

9. Industry or business in which work was done, as saw mill, bank, etc. odd jobs

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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 114 39 B. Howard Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 19 1938

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 \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) C. H. Appleberry, M. D.  
(Address) Flat River Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

