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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24109

Registration District No. 1003 — SEC'D AUG 1 1 1939 — 791

Primary Registration District No.

Registrar's No. 6382

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4330 Warne Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 50 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri 1 (b) County

(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. 4330 Warne Avenue
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 50 years years.

3. (a) PRINT FULL NAME KATE KENDALL 534

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Fred Kendall

6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased June 26, 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
74	0	22	hr. min.

9. Birthplace (City, town, or county) England 4 (State or foreign country)

10. Usual occupation 4

11. Industry or business At Home

FATHER
12. Name John Lytton 4
13. Birthplace (City, town, or county) England (State or foreign country)

MOTHER
14. Maiden name Katherine Hartford
15. Birthplace (City, town, or county) England (State or foreign country)

16. (a) Informant's own signature Katherine Kendall
(b) Address 4330 Warne Av

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-39 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Math Hermann & Son.
(b) Address 2161 East Fair Avenue

19. (a) JUL 19 1939 (Date received local registrar) (b) J. F. Bardeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1939 hour 11 minute 0 A M.

21. I hereby certify that I attended the deceased from July 8, 1939 to July 18, 1939
that I last saw her alive on July 18, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions Uremia caused by chronic nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature W. E. Morris M.D. (M. D. or other)
Address 4005 W Florissant Date signed 7-19-39

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed William J. Buchholz

Licensed Embalmer No. 2110

P. O. Address St Louis Mo

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.)

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