DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 13 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37536

Registration District No. 791 Primary Registration District No. _____ Registrar's No. 9375

1. PLACE OF DEATH: 1003

(a) County _____

(b) City or town St. Louis, Missouri 1
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ In this community 65 yrs. 10 mos. 25 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")

(d) Street No. 5568 Labadie Ave
(If rural, give location)

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

3. (a) PRINT FULL NAME Joseph Kenney 5

8. (b) If veteran, name war No 492-03-39 No 36

8. (c) Social Security No

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Dora

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

7. Birth date of deceased 12-4 (Month) 1875 (Day) (Year)

8. AGE: Years 65 Months 10 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Engineer Sta.

11. Industry or business Brick Laundry

MOTHER FATHER

12. Name Lawrence Kenney 5

13. Birthplace Unknown (City, town, or county) Ireland (State or foreign country)

14. Maiden name Jane Casey

15. Birthplace Unknown (City, town, or county) Ireland (State or foreign country)

16. (a) Informant's own signature Peter Scott

(b) Address 5400 Arsenal St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2 1939 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Chas F. Smart

(b) Address 1225 Union Blvd

19. (a) NOV 1 1939 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29th. year 1939 hour 5:45 minute p.m. M.

21. I hereby certify that I attended the deceased from July 1, 1939, 19__, to Oct. 29, 19 39 that I last saw him alive on Oct. 29, 19 39 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho- pneumonia 10-28-39

Due to _____

Due to Cerebral Accident Senility 7-1-39

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy No

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. Mo. Ly M.D. (M.D. or other)

Address 5400 Arsenal Date filed 11-3-39

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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 Albert E. Hopper

Licensed Embalmer No. 2977

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.