

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4647

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 33 Days  
(Specify whether  
In this community 35 Years  
years, months or days)

3. (a) PRINT FULL NAME Mr. Joseph H. Kennett  
8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Marr.  
6. (b) Name of husband or wife Mrs. Lillie E. Kennett 6. (c) Age of husband or wife if alive 57 years  
7. Birth date of deceased December 13 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
63 11 22 br. min.

9. Birthplace Monroe County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Contractor

11. Industry or business Cement Work

MOTHER FATHER  
12. Name James Kennett  
13. Birthplace Stoutsville Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Martha Bush  
15. Birthplace Stoutsville Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wald W. Schenkamp  
(b) Address 3005 East 54th St.

17. (a) Burial (b) Date thereof Dec. 9, 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director O. H. Newcomer Sons  
(b) Address 1401 Brush Creek Blvd.  
Dec. 7, 1939

19. (a) Dec. 7, 1939 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4929 Chestnut Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? ---- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5th  
year 1939 hour 8 minute 55 P. A. M.

21. I hereby certify that I attended the deceased from Oct 10, 1939 to Dec 5, 1939;  
that I last saw him alive on Dec 5, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Embolic (cerebral)  
Due to Past operative 46

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Carcinoma of desending colon  
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?

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

23. Signature Chas. F. Clark (M. D. or other)  
Address 223 Argyle Bldg. Date signed 12/7/39

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 *C. Herwig Quisenberry*

Licensed Embalmer No. *4070*

P. O. Address *D. C. Mo.*

**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.**