

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3645

Registration District No. 4465 Primary Registration District No. 6018B Registrar's No. 924

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Essex
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME

Homer W. Kennon

3. (b) If veteran, name war _____ 3. (c) Social Security No. V

4. Sex M 5. Color or race W 6. (a) Single, ~~widowed~~, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 25th 1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 10 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Cape Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name John D. Kennon

13. Birthplace Perry Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Margaret D. Needham

15. Birthplace Libertyville Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marjorie W. Kennon

(b) Address Essex, Mo

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

(c) Place: burial or cremation W.P. Cemetery (St. Francois)

18. (a) Signature of funeral director Baldwell Bros

(b) Address Flat River Mo

19. (a) 2-6-40 (b) O. Tharrel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois
(c) City or town Essex
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6th day Jan.
year 1940 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from 4-3, 1934, to 1-6, 1940
that I last saw him alive on 1-5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death angina pectoris
Duration four
minutes

Due to chronic myocarditis, infarcted several
& arterial sclerosis years

Due to _____
Other conditions none 71
(Include pregnancy within 3 months of death)

Major findings:
Of operations V

Of autopsy V
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) _____ V

(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) _____

(e) Means of injury _____

23. Signature Paul L. Jones M.D. (M. D. or other)

Address Flat River, Mo Date signed 1-6-40

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.....

Licensed Embalmer No.....

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.