

No. 2  
4-13-40  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34975  
Registrar's No. 340

NOV 15 1940

Registration District No. 12-d Primary Registration District No. 3009

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Cape Girardeau mo  
(b) City or town Cape Girardeau mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number for location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State mo (b) County Cape  
(c) City or town Advance mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Charles Edward Kennedy  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 10 day 8  
year 1940 hour 7 minute 15 M.

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 Sept 28 1940  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 28, 1940, to 10 - 8, 1940  
that I last saw him alive on Oct. 7, 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months 1 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Congenital umbilical hernia  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Advauce mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name Marlow Kennedy Kennedy  
13. Birthplace mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Jane Reed  
15. Birthplace mo.  
(City, town, or county) (State or foreign country)

Major findings: unbilical hernia  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant Karlson Kennedy  
(b) Address Advauce, mo.  
17. (a) Burial (b) Date thereof 10-10-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director Lloyd Morgan  
(b) Address Advauce mo.  
19. (a) 10-8-40 (b) Jim Thompson  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(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 Kwachler (M. D. or other)  
Address Cape Girardeau Date signed \_\_\_\_\_

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**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, fact should be so stated above.**