S. No. 2
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5-17-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37563

Registration District No. 791 — DEC 11 1940 — Primary Registration District No. 1003 — Registrar's No. 9836

129

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo. 3

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

(c) Name of hospital or institution Ozaman Shelter Home (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town St. Louis, mO 11 (If outside city or town limits write "RURAL")

(d) Street No. Ozman Shelter Home (If rural, give location)

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

3. (a) PRINT FULL NAME Edward Leo Kennedy

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M.

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased June 6, 1893 (Month) (Day) (Year)

8. AGE: Years 47 | Months 5 | Days 21 | If less than one day hr. min.

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

10. Usual occupation Janitor

11. Industry or business

FATHER
12. Name Michael Kennedy
13. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Catherine (Unknown)
15. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Freeman Land

(b) Address Jackson, Georgia.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/40. (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Und. Co.

(b) Address 2849 N. Euclid

19. (a) NOV 30 1940 (Date received local registrar) (b) J. F. Budick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 28 year 1940 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Fractured Skull

Due to with Cerebral Haemorrhage

Due to Time, Place, Cause and

Other conditions (Include pregnancy within 3 months of death) Manner of Same Could not

Major findings: Of operations Undetermined

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) Open Verdict

(b) Date of occurrence Unknown

(c) Where did injury occur? Unknown (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Unknown (Specify type of place)

While at work? (e) Means of injury

23. Signature Joseph M. [illegible] (M. D. or other)

Address Deputy Coroner Date signed

(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 Albert Mayfield

Licensed Embalmer No. 3077

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.