

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1413
373
Registrar's No. _____

Registration District No. 399

Primary Registration District No. 1002

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:
General Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution few minutes
(Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 49
(c) City or town Kansas City, Mo. 3
(If outside city or town limits, write "RURAL") 0
(d) Street No. 1861 Benton
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day 1-24-41
year _____ hour _____ minute _____
21. I hereby certify that I attended the deceased from 11:45 A.M.
_____ 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 _____

Pulmonary embolism & infarction of lung
Pelvic thrombosis

Duration

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

Major findings:
Of operations _____
Of autopsy Yes

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 W. M. Crow (M. D. or other) _____
Address K. C. Mo. Date signed _____

3. (a) PRINT FULL NAME WALTER KENNEDY

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Kate Kennedy 6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Feb. 10, 1856
(Month) (Day) (Year)

8. AGE: Years 84 Months 11 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Kentucky (City, town, or county) (State or foreign country)

10. Usual occupation Hotel Operator

11. Industry or business Retired

12. Name Zadock Kennedy

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

14. Maiden name Cynthia A. Collins (City, town, or county) (State or foreign country)

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

16. (a) Informant Fred F. Kennedy

(b) Address 6243 E. 15th Terrace

17. (a) Burial (b) Date thereof Jan. 27, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address 2825 Indep. Blvd. Kansas City, Mo.

19. (a) Jan. 26, 1941 (b) W. M. Crow
(Date received local registrar) (Registrar's signature)

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

39
492

1112

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 W.D. Blackman

Licensed Embalmer No. 3639

P. O. Address Kansas City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed; above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **373**

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:
General Hospital
(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 **Walter Kennedy**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Male** 5. Color or race **White** 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..... (Month) (Day) (Year)

8. AGE: Years **84** Months Days If less than one day
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

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

18. (a) Signature of funeral director..... (b) Address.....

19. (a) **Jan 26/41** (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. **1861 Benton**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

19. MEDICAL CERTIFICATION
20. DATE OF DEATH Month **Jan.** day **24th**
year **1941** hour..... minute..... M.

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

Immediate cause of death **Pulmonary embolism & infarction**

Due to **Pelvic Thrombosis**

Due to..... **11/10**

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

Major findings: Of operations.....

Of autopsy **Yes**

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?.....

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

23. Signature **Victor B. Buhler** (M. D. or other).....
Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-1413

