

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11767

REC'D APR 28 1947 45
Primary Registration District No. 4431

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Registrar's No. _____

1. PLACE OF DEATH: Ralls
(a) County Ralls
(b) City or town Center
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community 10 yrs
years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME Thomas Kennedy

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race white 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 Jan 20 1858
(Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Thomas Kennedy

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

14. Maiden name Valera Gibson

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

16. (a) Informant's own signature Larise Kennedy

(b) Address Center, Mo

17. (a) Buried (b) Date thereof 4/18/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Price Center

18. (a) Signature of funeral director Garrett

(b) Address Center Mo

19. (a) 4/21 (b) Garrett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ralls
(c) City or town Center
(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. 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15
year 1947 hour 5 minutes 30 a.m.

21. I hereby certify that I attended the deceased from May 4
_____ 1939 to March 17 1947
that I last saw him alive on March 14 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Myocardial infarction - Unknown

Due to Chronic

Other conditions none known
(Include pregnancy within 3 months of death)

Major findings: _____ PHYSICIAN _____

Of operations _____ Underline the cause to which death should be charged statistically

Of autopsy _____

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? _____

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

23. Signature C. H. Brody (M. D. or other) Do
Address Center Mo Date signed 4-8-47

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

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.

1 x1811

RECEIVED

District Health Officer No. 10

District File Number 447-833

Date Filed APR 14 1941

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

Guss W. Allen

Registered Apprentice No. _____

working under my personal supervision.

Signed

Guss W. Allen

Licensed Embalmer No. 5382

P. O. Address Center St

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.