

FILED AUG 20 1941

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

24954  
Do not use this space.

1. OF DEATH  
(a) County Dallas Registration District No. 241 030  
(b) Township S. Benton Primary Registration District No. 1254 3  
(c) City or City (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James L. Kennedy  
(a) Residence, No. [Redacted] St. [Redacted]  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (write the word)  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) about 1880  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hra. or .....min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas  
13. NAME Unknown  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?  
15. MAIDEN NAME ?  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?  
17. INFORMANT Alva E. Gamel  
(ADDRESS) Buffalo Mo  
18. BURIAL, CREMATION, OR REMOVAL  
PLACE W. Hope DATE 7-24-41  
19. FUNERAL DIRECTOR (NAME) L. B. Jones  
(ADDRESS) Buffalo Mo  
20. FILED 8-10-41 HARRY MOTIN  
210 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-23-41  
22. I HEREBY CERTIFY, That I attended deceased from March, 1941, to 7-23, 1941  
I last saw him alive on 7-22, 1941 Death is said to have occurred on the date stated above, at 8 a.m.  
The principal cause of death and related causes of importance were as follows:  
apoplexy  
43  
Other contributory causes of importance:  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) D. H. Gummert M. D.  
(Address) \_\_\_\_\_

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.

RECEIVED  
District Health Officer No. 7  
District File Number 8-41-1356  
Date Filed 8-19-41

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 *Clyde Montgomery*  
Licensed Embalmer No. *3592*  
P. O. Address *Buffalo Mo*

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.

Registration District No. *241*  
*264*

Primary Registration District No. *5334*

Registrar's No. *1290*

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

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State *unknown* County  
(b) City or town  
(If outside city or town limits, write "RURAL")  
(d) Street No. *Rural*  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME *James G. 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 *M*  
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 *about 60* Months Days *min* If less than one day

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

10. Usual occupation

11. Industry or business

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) (Date received local registrar) (b) *Harry Momy* (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

21. I hereby certify that I attended the deceased from *9* 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* Duration

Due to

Due to *This man died in poor home*

Other conditions *could have been died that*  
(Include pregnancy within 5 months of death) *How any thing about*

Major findings: Of operations

Of autopsy

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

1941  
S-24955