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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

26484

State File No.

Registration District No. 904 Primary Registration District No. 6215 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Worth
(b) City or town Grant City
(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 (Specify whether
In this community 22 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Worth 113
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Grant city 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? () years.

3. (a) PRINT FULL NAME FRANK MANFUL 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 Married

6. (b) Name of husband or wife Emma Kennedy

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

7. Birth date of deceased Feb (Month) 21 (Day) 1870 (Year)

8. AGE: Years 71 Months 4 Days 20 If less than one day hr. min.

9. Birthplace Columbia Co. (City, town, or county) / Ohio (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Jahu Manful Kennedy
13. Birthplace Carroll Co. (City, town, or county) / Ohio (State or foreign country)

MOTHER
14. Maiden name Sarah Elizabeth Great
15. Birthplace Unknown (City, town, or county) / Indiana (State or foreign country)

16. (a) Informant Emma Kennedy
(b) Address Grant city Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13 1941 (Month) (Day) (Year)
(c) Place: burial or cremation Mount Vernon

18. (a) Signature of funeral director Arch C. Trimble
(b) Address Grant City Mo.

19. (a) July 13 1941 (Date received local registrar) (b) Mrs O. H. Bond (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11 year 1941 hour minute 3:30 P.M.

21. I hereby certify that I attended the deceased from June 4 1941, to July 11 1941; that I last saw him alive on July 6 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypertensive heart disease	1 yr
Due to ✓	
Due to ✓	
Other conditions (Include pregnancy within 3 months of death): ✓	
Major findings: ✓ Of operations	
Of autopsy NU	

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

23. Signature R. Ross M.D. (M. D. or other) ()
Address Grant City Mo Date signed 7-12-41

(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 Arch C. Dunfee

Licensed Embalmer No. 3252

P. O. Address Grant City M

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

If this body is not embalmed, fact should be so stated above.