

S. No. 2
M-1-4-41
v. 5-17-39
X26398

DEPARTMENT OF COMMERCE
BUREAU OF HEALTH

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27105**
Registrar's No. **6897**

FILED SEP 17 1941

Registration District No. **7911** Primary Registration District No. **1003**

-6140

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

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether
15 Days years, months or days)

In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....

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

(d) Street No. 3009a N. 20th. St.
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Charles Cleo Kennedy

(b) If veteran, name war No. (c) 498 Service No. 272 No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24
year 1941 hour 7:28 minute..... P. M.

21. I hereby certify that I attended the deceased from August 10
1941 19..... to August 24 19 41
that I last saw him alive on August 24 19 41
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Virginia Kennedy 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased September 22 1880
(Month) (Day) (Year)

Immediate cause of death
Pulmonary Tuberculosis

8. AGE: Years Months Days If less than one day
60 11 2 hr. min.

Due to.....

Due to.....

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

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

10. Usual occupation Unemployed

Major findings:
Of operations.....

Of autopsy eyes 2-3

PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business.....

MOTHER FATHER { 12. Name Geo. Danial Kennedy

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

14. Maiden name Addie Hill

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

16. (a) Informant Virginia Kennedy

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?.....

(b) Address 3009a N. 20th. St.

17. (a) Burial (b) Date thereof 8-27-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

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

23. Signature M. M. Kael (M. D. or other) S
Address 1515 Lafayette Date signed 8/25/41

18. (a) Signature of funeral director Hv. Leidner Und. Co.
(b) Address 2223 St. Louis Ave

19. (a) AUG 25 1941 (b) J. H. Bruck
(Date received local registrar) (Registrar's signature)

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..... *John P. Buckley*

Licensed Embalmer No. *1674*

P. O. Address *7723 St. Louis*

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, fact should be so stated above.