

5-17-39  
X23159

Registration District No. 531

Primary Registration District No. 5718

1. PLACE OF DEATH:

(a) County Macon

(b) City or town New-Cambria Rural, Russell  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Rural  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none. (Specify whether)

In this community 1 year  
years, months or days

2. USUAL RESIDENCE OF DECEASED

(a) State MO County Macon

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME BRIDGET ANN KENNEDY

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

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

6. (b) Name of husband or wife Sam Kennedy 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 1 1859  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>8</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Thos. Quealy

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Thomas Kennedy

(b) Address New Cambria

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookfield

18. (a) Signature of funeral director J. G. Hillland

(b) Address New Cambria, Mo.

19. (a) Sept 9 - 1941 (b) J. G. Hillland  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8  
year 1941 hour 5 minute AM

21. I hereby certify that I attended the deceased from Aug 8 1941 to Sept 7 1941;  
that I last saw her alive on Sept 7 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Drooping

Due to respiration

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy no

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 Covert (M. D. or other) \_\_\_\_\_

Address New Cambria, Mo. Date signed Sept 9 - 1941

Duration 6 mo

17x

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

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

6100

RECEIVED

District Health Officer No. 10

District File Number 10-41-1800

Date Filed OCT 24 1941

EMBALMER  
1000  
1000

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

H. J. Gilleland

Licensed Embalmer No.

4019

P. O. Address

New Cambria, 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, fact should be so stated above.

Registration District No. 531

Primary Registration District No. 2718

1. PLACE OF DEATH:

- (a) County Macon
- (b) City or town \_\_\_\_\_  
(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 \_\_\_\_\_  
years, months or days)

- 3. (a) PRINT FULL NAME Bridget A. Kennedy
- 3. (b) If veteran, name war \_\_\_\_\_
- 3. (c) Social Security No. \_\_\_\_\_

- 4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

- 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

- 7. Birth date of deceased Jan 1 1859  
(Month) (Day) (Year)

- 8. AGE: Years 82 Months 8 Days \_\_\_\_\_ (If less than one day, hr. min.)

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

- 10. Usual occupation \_\_\_\_\_

- 11. Industry of 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) \_\_\_\_\_ (b) Date thereof Sept 10-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation \_\_\_\_\_

- 18. (a) Signature of funeral director \_\_\_\_\_

- (b) Address \_\_\_\_\_
- 19. (a) Sept 11-41 (b) J. R. Shackelford  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month Sept day \_\_\_\_\_ year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

- 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; \_\_\_\_\_ 19\_\_\_\_;

that I last saw him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to chronic dropsy  
nephritis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_
- (b) Date of occurrence \_\_\_\_\_

- 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

M.C.O. West-71

1941

5-31989