

No. 2
4-41
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15833

State File No.

FILED MAY 15 1942
Registration District No.

Primary Registration District No. 6162

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Washington Town Ship
(If outside city or town limits, write "RURAL," add name of township)

(c) Name of hospital or institution: State Hospital No 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon 108

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

(d) Street No. Unknown
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ELSWORTH KENNEDY

3. (b) If veteran, name war Unknown

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6th
year 1942 5 hour 0 minute A. M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mrs Stella Kennedy

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

7. Birth date of deceased July 17th 1880
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 10th 1942, to April 15th 1942
that I last saw him alive on April 15th 1942
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>8</u>	<u>27</u>	hr. min.

Immediate cause of death
Hypertensive Heart Dis with Congestive Heart failure

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

Due to

Due to

10. Usual occupation Miller

Other conditions Terminal Pneumonia
(Include pregnancy within 3 months of death)

11. Industry or business Railroad

Major findings:
Of operations

12. Name John William Kennedy

Of autopsy

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

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

14. Maiden name Jane Hadwin

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

16. (a) Informant Mrs Stella Kennedy

(b) Address Monteville

17. (a) Buried (b) Date thereof April 16 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation olive Branch cemetery

18. (a) Signature of funeral director G. B. Perry & Sons

(b) Address Sheldon Mo.

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?

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

While at work?

23. Signature G. S. Wataich (M. D. or other) 0

Address Nevada, Mo Date signed 4/15/42

1236 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File Number

Date Filed

3-42-574

5-13-42

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

Carroll T. Beeny

Licensed Embalmer No. 2385

P. O. Address Sheldon 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. 875

Primary Registration District No. 6162

Registrar's No.

1. PLACE OF DEATH: Vernon Rural
 (a) County.....
 (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 Elsworth 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 July 17 1881
 (Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 17 If less than one day..... min.

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

10. Usual occupation.....

11. Industry or 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..... (Month) (Day) (Year)
 (Burial, cremation, or removal)
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a)..... (b)..... (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 Apr Day 19 Year 1942 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... 19.....
 that I have examined the body on..... 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Due to..... pneumonia, broncho.

Due to.....
 Other conditions..... (Include pregnancy within 3 months of death) 107

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.....
 (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?

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

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

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

SUPPLEMENTARY

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

1942

S-158'33