

FILED JUN 18 1942 3

Registration District No. _____

Primary Registration District No. 6211

1. PLACE OF DEATH:

(a) County North
(b) City or town Rural
(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 50 years years, months or days

3. (a) PRINT FULL NAME EMMA KENNEDY

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

4. Sex girl 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Frank M. Kennedy 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept. 19 - 1881 (Month) (Day) (Year)

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

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown 9.
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Unknown 9.
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Lester Huff
(b) Address Grant City, Mo.
17. (a) Rural (b) Date thereof 5-29-42 (Month) (Day) (Year)
(c) Place: burial or cremation Mr. Vernon cem.

18. (a) Signature of funeral director John C. Dunfee
(b) Address Grant City, Mo.
19. (a) June 2, 1942 (b) Archie Scadden (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 27 year 1942 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from 5-27 1942 to 5-27 1942
that I last saw her alive on 5-27 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 92 f

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 Archie Scadden (M. D. or other) _____
Address Grant City, Mo. Date signed 5-28-42

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..... *Arch C. Dumble*.....
Licensed Embalmer No..... *3252*.....
P. O. Address..... *Havant City, 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.