

No. 2
9-4-41
-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26950

FILED SEP 12 1942

Registration District No. 72 Primary Registration District No. 5289

Registrar's No. 64

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town North Kansas City R. P. #8
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R#8 North Kansas City
(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 Charles Smith Kennedy

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

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife Ida Mae Kennedy 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 13, 1862
(Month) (Day) (Year)

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

80 4 19 _____ hr. _____ min.

9. Birthplace High Point North Carolina
(City, town, or county) (State or foreign country)

10. Usual occupation Mill Wright

11. Industry or business _____

12. Name Pleasant Kennedy

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

14. Maiden name Sarah Jordan

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

16. (a) Informant Marie Kennedy Olsen

(b) Address _____

17. (a) Burial (b) Date thereof Aug 5, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Forest Hill, K.C. Mo.

18. Signature of John S. Morton Morton Funeral Home

(b) Address 852 Armour Rd. N. K.C. Mo.

19. (a) Aug 3-1942 (b) Rich N. Henry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay

(c) City or town Rural #8
(If outside city or town limits, write "RURAL")

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2nd
year 1942 hour 6:55 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to August 2, 1942, and that death occurred on the date and hour stated above.

that I last saw him alive on August 2, 1942, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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? _____

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

23. Signature J. S. Fater (M. D. or other) _____
Address North Kansas City, Mo. Date signed 8/3/42

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 9-10-42

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

Leon E. Hodges

Licensed Embalmer No.

2729

P. O. Address

*832 Armour Ave.
North R.C. 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.

No. 2
9-4-41
5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Jan

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 72

Primary Registration District No. 5289

Registrar's No. 64

1. PLACE OF DEATH:

(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 15 years years, months or days)

3. (a) PRINT FULL NAME Charles Smith Kennedy

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

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

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			 hr. 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 Marie Kennedy Olson

(b) Address 1325 E 62nd Avenue KC Mo

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director John S Morton

(b) Address No. R.C. Mo

19. (a) Sept 9-42 (b) Ruth N Henry
(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 Aug day 2
year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 9-10-42.....

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.....

Licensed Embalmer No.....

P. O. Address.....

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.