

V. S. No. 2
 50M-542
 Rev. 5-17-39
 X32873

12356

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.
 Registrar's No. **3750**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town **St. Louis, Mo.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
City Hospital
 (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)

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. **3950 Russell Ave.**
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Edward F. Kennedy**
 3. (b) If veteran, name war..... 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **April** day **20th**
 year **1943** hour **8:55** minute..... P. M.

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, **widowed**
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased **Sept. 17th 1878**
 (Month) (Day) (Year)

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.

8. AGE: Years Months Days If less than one day
64 **7** **3**..... hr. min.

Immediate cause of death.....
**Chronic Myocarditis;
 Arteriosclerosis.**
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

9. Birthplace **Bunker Hill, Ill.** (City, town, or county) (State or foreign country)
 10. Usual occupation **Optician**

PHYSICIAN
 Underline the cause to which death should be charged statistically.
 Major findings:
 Of operations.....
 Of autopsy.....

MOTHER FATHER

11. Industry or business.....
 12. Name **William Kennedy**
 13. Birthplace **Ireland** (City, town, or county) (State or foreign country)
 14. Maiden name **Mary McPhillips**
 15. Birthplace **Ireland** (City, town, or county) (State or foreign country)

16. (a) Informant **Harold Braun**
 (b) Address **1108 Sanford Ave.**

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?

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Apr. 23, 1943**
 (Month) (Day) (Year)
 (c) Place: burial or cremation **Calvary Cemetery**
 18. (a) Signature of funeral director **Bromschwig Und. Co.**
 (b) Address **4746 West Florissant Ave**
APR 22 1943 (Date received local registrar)
J. F. Bredek (Registrar's signature)

White at work?..... (Specify type of place)
 (e) Means of injury.....
 23. Signature **James J. Fitzmaurice** (M. D. or other health officer)
Boyd Clark (Licensed Embalmer)
 Date signed **4-22-43**

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

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 Esq W Wilkison
Licensed Embalmer No. 3575
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.