

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13736

State File No. _____

Registrar's No. 490

Registration District No. 42

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
405 No. 12th
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Roy Lee Kennard

3. (b) If veteran, name war World War #1 3. (c) Social Security No. 491-09-7376

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

6. (b) Name of husband or wife Dellia 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased June 22 1892
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>10</u>	<u>4</u>	_____ hr. _____ min.

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

10. Usual occupation Barber

11. Industry or business _____

MOTHER FATHER { 12. Name Robert Kenard

{ 13. Birthplace Unknown 9

{ 14. Maiden name Elsie Kenard

{ 15. Birthplace Unknown 9

16. (a) Informant Mrs Leroy Kenard

(b) Address 405 No. 12th St Joseph, Mo

17. (a) Burial (b) Date thereof 4-28-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cem

18. (a) Signature of funeral director Fleeman & Son Inc

(b) Address 1946 Colhoun St

19. (a) 4-28-43 (b) Rose Herzog
(Date received final register) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

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

(d) Street No. 405 No. 12th
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26
year 1943 hour 10 minute _____ A. M.

21. I hereby certify that I attended the deceased from April 13
1943 to April 26 1943
that I last saw him alive on April 26 1943
and that death occurred on the date and hour stated above

Immediate cause of death Encephalitis from History

Due to chronic Alcoholism

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 1240

Of operations _____

Of autopsy _____

Duration 3 1/2 years

PHYSICIAN

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) (a) Means of injury _____

23. Signature Dr. John H. Klesner (M. D. or other)

Address 1097 1/2 7th St Joseph MO Date signed 4/28/43

1233

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

MAY 13 1943

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..... *Robert H. Gable*

Licensed Embalmer No. *3308*

P. O. Address..... *St. Joseph 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.