

7. S. No. 2  
DM-1-4-41  
rev. 5-17-39  
P1 X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2128

FILED JAN 25 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 15.50

Registrar's No. 1572

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1213 N 10th St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 Mths.  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton  
(c) City or town Cameron  
(If outside city or town limits, write "RURAL")  
(d) Street No. 422 N Walnut St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 9  
year 1944 hour 10:45 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Dec 20 1943 to Jan 9 1944  
that I last saw him alive on 1-9 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death  
cerebral hemorrhage 14 hrs  
Duration

Due to: \_\_\_\_\_  
Due to: \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature J. R. Elliott (M. D. or other) MD  
Address 501 1/2 Franklin St. Date signed 1-9-44

3. (a) PRINT FULL NAME John Walter Kenney

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

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

6. (b) Name of husband or wife Margaret C Kenney 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 3, 1864  
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired R.R. workman

11. Industry or business \_\_\_\_\_

12. Name John Walter Kenney

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

14. Maiden name Margaret Whigley

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

16. (a) Informant Rose Kenney

(b) Address Cameron, Mo.

17. (a) Burial (b) Date thereof 1-10-44  
(Burial, cremation, or reinterment) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cem. St. Joseph

18. (a) Signature of funeral director Poland Funeral Home

(b) Address Cameron, Mo.  
19. (a) 1-10-44 (b) Rose Kenney  
(Date received local registrar) (Registrar's signature)

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

11  
1  
7

**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 Gerald Wade

Licensed Embalmer No. 4172

P. O. Address Cameron 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.**