

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

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

FILED MAR 27 1944

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

Elizabeth Kennedy
 11951

Registration District No. 316

Primary Registration District No. 3061

Registrar's No. 105

1. PLACE OF DEATH:

(a) County St. Francois
 (b) City or town St. Robert
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... (Specify whether years, months or days)

In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Elizabeth Kennedy

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased Nov 23 1871
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 3 14 hr. min.

9. Birthplace Mine La Motte Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name William Fortner

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

14. Maiden name Eliza Deans

15. Birthplace Mine La Motte
 (City, town, or county) (State or foreign country)

16. (a) Informant James Kennedy

(b) Address St. Robert Mo

17. (a) Burial (b) Date thereof 3 9 44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Ann Cemetery

18. (a) Signature of funeral director Geo Deans

(b) Address 513 E. Main St. Robert Mo

19. (a) MARCH 8, 1944 (b) Byrdie Bukhreste
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
 (c) City or town St. Robert
 (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 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 7
 year 1944 hour 7 minute 4 M.

21. I hereby certify that I attended the deceased from 1-20-44 to 3-7-44
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumo-pneumonia

Due to.....
 Due to.....

Other conditions In R hip
 (Include pregnancy within 3 months of death)
 Major findings: Generalized nephritis
Other hyperthyroidism
 or 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 Feb 23 1944
 (c) Where did injury occur? Centerville St. Francois Mo.
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
in home

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

23. Signature W. G. Earle (M. D. or other)
 Address St. Robert Date signed 3-8-44

Duration 3 d

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAR 2 9 1944

RECEIVED

District Health Officer No. 4
District File Number 344-3580
Date Filed 3-24-44

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

Geo Diesner

Licensed Embalmer No. 970

P. O. Address Flat River

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.