

1-2-43  
5-17-39  
X35697

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12395

State File No. \_\_\_\_\_

Registrar's No. 62

FILED APR 14 1944  
Registration District No. 1948

Primary Registration District No. 6225

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Rural Washburn Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
State Hosp #3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 2 yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Missouri 108  
(c) City or town Hannibal Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 313 S. 5th  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

JUNA. KENYON

(b) If veteran, name war no

(c) Social Security No. ?

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced single  
7. Birth date of deceased Aug - 22 1874  
(Month) (Day) (Year)

8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Hospital attendant

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

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant: Self

(b) Address State Hosp. Nevada Mo

17. (a) Removal (b) Date thereof 3-30-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hannibal Mo

18. (a) Signature of funeral director Richard F. ... (Specify type of place) \_\_\_\_\_

(b) Address Nevada Mo (c) Means of injury \_\_\_\_\_

19. (a) 3-30-44 (b) Boyd B. Burch  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 30  
year 1944 hour 7 minute 10 a.m.

21. I hereby certify that I attended the deceased from Jan - 24 - 44  
19\_\_\_\_ to 3/20/44 19\_\_\_\_;  
that I last saw her alive on 3/20/44 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death acute glomerulonephritis  
Due to \_\_\_\_\_

Duration

2 mos

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

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations none

PHYSICIAN

Underline the cause to which death should be charged statistically.

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Frank M. ... (M. D. or other) \_\_\_\_\_

Address State Hosp #3 Date signed 3/30-44

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

MOTHER FATHER

1331

DEC 1 1947

MT 8 AM

RECEIVED

District Health Officer No. 76

District File Number 3-44-516

Date Filed 4-12-44

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 Marsh Eicheger

Licensed Embalmer No. 2656

P. O. Address Nevada, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
62  
Registrar's No. 62

Registration District No. 360

Primary Registration District No. 6220

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

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural Washington Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
State Hospital no 3 - Nevada  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months  
- 11 days (Specify whether  
In this community yes  
years, months or days)

3. (a) PRINT FULL NAME JUNA KENYAN

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife none

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

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

8. AGE: Years 69 Months 2 Days 28 If less than one day, in min.

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

10. Usual occupation Attendant State Hosp

11. Industry or business none - Nevada

12. Name Unknown

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

14. Maiden name unknown unknown

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

16. (a) Informant Records State Hosp No 3

(b) Address Nevada, Mo.

17. (a) (Burial, cremation, or removal)

(b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar)

(b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

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

(d) Street No. 315 South 5<sup>th</sup>  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 30 Year 1944 Hour 10 Minute A.M.

21. I hereby certify that I attended the deceased from Jan 19/44 to March 30, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death acute glomerular nephritis

Due to Chronic Nephritis on Arteriosclerotic basis

Due to infection

Other conditions none except 1/3/44  
(Include pregnancy within 3 months of death)

Generalized Arteriosclerosis

Major findings: no operation

Of operations

Of autopsy no autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence none

(c) Where did injury occur? none  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none  
(Specify type of place)

While at work? none (c) Means of injury none

23. Signature Frank M. Rogers (M. D. or other)

Address State Hosp No 3 Date signed 6-7-44

**MENTAL**

6666

PHYSICIAN

Underline the cause to which death should be charged statistically.

12395