S. No. 2
1—9-4-41
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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35488

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 10 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 340 Primary Registration District No. 6151 Registrar's No. 28

1. PLACE OF DEATH:
(a) County Stoddard County
(b) City or town 5 miles S SW of Canalou, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: —
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
In this community 2 months, 3 days (Specify whether years, months or days) 1

2. USUAL RESIDENCE OF DEACESED:
(a) State Illinois (b) County 997
(c) City or town Chicago 11
(If outside city or town limits, write "RURAL")
(d) Street No. 8441 Drexel Avenue 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Kennedy, William Edward
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Male 0
5. Color or race W
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased June (Month) 21 (Day) 1925 (Year)

8. AGE: Years 19 Months 2 Days 18 If less than one day — hr. — min.

9. Birthplace Chicago (City, town, or county) Illinois (State or foreign country) 1
10. Usual occupation Avn/Cadet, Army of United States
11. Industry or business Army of United States

FATHER
12. Name Horace Hugh Kennedy, Sr.
13. Birthplace Chicago (City, town, or county) Illinois (State or foreign country) 1

MOTHER
14. Maiden name —Unknown
15. Birthplace —Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Service Record of Soldier 1
(b) Address 256lst AAF Base Unit, Sikeston, Mo
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 10-10-44 (Month) (Day) (Year)
(c) Place: burial or cremation Chicago Ill
18. (a) Signature of funeral director Wells Funeral Home
(b) Address Sikeston Mo
19. (a) 10-18-44 (Date received local registrar) (b) Cardie Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9 year 1944 hour 10 minute 55 A.M.
21. I hereby certify that I attended the deceased from No Attendance, 19..., to —, 19...;
that I last saw h. — alive on — — 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death Severe head injuries with multiple fractures and contusions. Partial evisceration. — Duration
Due to Aircraft accident.
Due to —
Other conditions — (Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy None Performed

1738
34

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) Aircraft Accident
(b) Date of occurrence 9 October 1944 11
(c) Where did injury occur? 5 mi. S SW of Canalou, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? On a farm (Specify type of place)
While at work? Yes (e) Means of injury Aircraft
23. Signature Henry C. Doobies, Capt. MC (M.D. or other) M.D.
Address 256lst AAF Base Unit, Sikeston, Mo. Date signed 9 Oct 44

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1144-479
Date Filed 11-6-44

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.