

#37063

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **39496**

FILED JAN 5 1944

Primary Registration District No. **1000**Registrar's No. **11203**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
 (Specify whether
 In this community 0
 years, months or days)

3. (a) PRINT FULL NAME Daniel Kennedy3. (b) If veteran, name war none 3. (c) Social Security No. none4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased November 19 1882
(Month) (Day) (Year)8. AGE: Years 62 Months 1 Days 9 If less than one day _____ hr. _____ min.9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)10. Usual occupation laborer

11. Industry or business _____

12. Name Michael Kennedy13. Birthplace Ireland
(City, town, or county) (State or foreign country)14. Maiden name Margaret Daly15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)16. (a) Informant Wm P. Daly(b) Address 8224 So. Broadway17. (a) burial (b) Date thereof 12-30-44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Calvary Cemetery18. (a) Signature of funeral director Southern Funeral Home(b) Address 6223 South Grand Blvd19. (a) DEC 29 1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County [blank]
 (c) City or town city of St. Louis
 (If outside city or town limits, write "RURAL")
 Street No. 111 Upton St.
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country [blank]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28th
year 1944 hour 1:35 minute A. M.21. I hereby certify that I attended the deceased from 12/25/44
19____ to 12/28/44 19____;
that I last saw him im alive on 12/28/44 19____;
and that death occurred on the date and hour stated above.Immediate cause of death myocardial failure Duration _____Due to urremiaDue to Benign Prostatic HypertrophyOther conditions lobar pneumonia, bilateral
(Include pregnancy within 3 months of death)Major findings:
Of operations _____Of autopsy Chronic pyelonephritis, adv
Bronchopneumonia, advanced

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) (e) Means of injury _____

23. Signature J. A. Layton, Jr. (M. D. or other) _____
Address 1515 Lafayette 12/28/44
Date dictated

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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..... *Virgil L. Berryman*.....

Licensed Embalmer No. *4018*.....

P. O. Address..... *St. Louis, 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.