

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED FEB 6 1945

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11-15-44-1-21-45
In this community 56 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 42
(c) City or town Kansas City Mo. 3
(If outside city or town limits, write "RURAL")
(d) Street No. 8821 Iriquois Trail. 8
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Margaret A. KENNEDY.

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Michael J. Kennedy 6. (c) Age of husband or wife if alive ----- years
7. Birth date of deceased June 30th, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 6 21 hr. min.

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

10. Usual occupation House Wife.

11. Industry or business

MOTHER FATHER

12. Name Robert Kane
13. Birthplace Belfast Ireland 4
(City, town, or county) (State or foreign country)
14. Maiden name Bridget A. Hanrahan
15. Birthplace County Clave Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Michael J. Kennedy Jr.
(b) Address Ambassador Hotel.

17. (a) Burial (b) Date thereof 1/24/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Melody-McGilley
(b) Address Kansas City Mo.

19. (a) 1-23-45 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 21st.
year 1945 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from Nov. 15, 1945, to Jan 21, 1945;
that I last saw her alive on Jan 21, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death

Myocardial degeneration
of coronary artery Unknown
duration

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93rd 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?

While at work? _____ (Specify type of place) _____ (Means of injury)
23. Signature G. Weston Quobus (M.D. or other) MD
Address 420 Prof Bldg Date signed 1-23-45

Dr. M.Ginsberg.

Prof. Bldg.

Vi. 3737

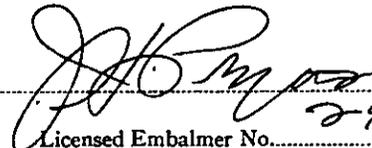
2 P.M.

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.....



Licensed Embalmer No.....

2999

P. O. Address.....

KC

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.