

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4442

State File No. _____
Registrar's No. **1680**

FILED MAR 9 1945
Registration District No. **013**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

(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:
Homer G. Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 days**
(Specify whether)

In this community **Life**
years, months or days

3. (a) PRINT FULL NAME **Edmund Kennell**

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

4. Sex **Male 2** 5. Color or race **Colored**

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

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

7. Birth date of deceased: **Oct. 3 1944**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
	4	13	hr. _____ min. _____

9. Birthplace: **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

MOTHER FATHER

11. Industry or business _____

12. Name **Dennis Kennell**

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

14. Maiden name **Anna Sanders**

15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Anna Kennell (Mother)**

(b) Address **3167a Evans Avenue**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Feb. 21-45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park, Ceme**

18. (a) Signature of funeral director **Peoples Und. Co.**

(b) Address **3100 Franklin Avenue (6)**

19. (a) **FEB 20 1945** (b) *J. Thredwell*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **000**

(a) State **Missouri** (b) County **12**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **3167 Evans**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **6**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **16**, year **1945** hour **2** minute **10 P. M.**

21. I hereby certify that I attended the deceased from **February 6**, 19**45** to **February 16**, 19**45**; that I last saw him alive on **February 16**, 19**45**; and that death occurred on the date and hour stated above.

Immediate cause of death: **Bronchopneumonia** **10 days**
Prob. Pneumococcal Meningitis

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

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? _____

23. Signature *W. C. Galloway* (M. D. or other) _____
Address **260 W. Hittler** Date signed **2/19/45**

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... *Joseph H. Pettus*

Licensed Embalmer No. *4184*

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.