S. No. 2
M—5-42
5-17-39
I X32873

2691

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 25 1946

State File No. 491

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 502

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Park Lane Hospital
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 800

(c) City or town St. Louis 517
(If outside city or town limits, write "RURAL")

(d) Street No. 5624 Cabanne Ave., 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Jennie Kennedy.

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Edward Kennedy

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

7. Birth date of deceased Feb. 28, 1862.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
83	10	18	hr. min.

9. Birthplace Rochester, New York
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Tom Dragon
13. Birthplace France
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Don't Know
15. Birthplace France
(City, town, or county) (State or foreign country)

16. (a) Informant Granville A. Kennedy
(b) Address 5624 Cabanna Ave.,

17. (a) Burial (b) Date thereof Jan. 17/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,

19. (a) JAN 16 1946 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day ~~17~~ 15
year 1946 hour 10.20 minute A.M. M.

21. I hereby certify that I attended the deceased from 1-13-46, 19, to 1-15-, 1946;
that I last saw her alive on 1-15, 1946;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Chronic Myo-Cardixis	
Due to Arteriosclerosis	?
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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M.D. or other) M.D.

Address 4930 Lindell Blvd St. Louis, Mo Date signed 1-16-46

(Licensed Embalmer's Statement on Reverse Side)

Dr. Smith
Park Lane Hospital

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. 2663

P. O. Address 1125 Hodiamont Ave.,

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.