S. No. 2
M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7700

FILED FEB 20 1946

Registration District No. 1003 Primary Registration District No. Registrar's No. 1290

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:
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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5028 Cabanne Avenue,
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3. (a) PRINT FULL NAME FRANK McKENNA

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

4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lee Mc Kenna
6. (c) Age of husband or wife if alive years
7. Birth date of deceased November 14th 1889 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
56	2	21	hr. min.

9. Birthplace St. Louis, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Electrician
11. Industry or business

FATHER
12. Name Patrick Mc Kenna
13. Birthplace St. Louis, Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary O'Hara
15. Birthplace St. Louis, Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lee Mc Kenna - Wife,
(b) Address 5028 Cabanne Avenue,
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 2-8-1946 (Month) (Day) (Year)
(c) Place: burial or cremation Int. Calvary Cemetery
18. (a) Signature of funeral director Sullivan Brothers,
(b) Address 2849 North Euclid Avenue,
19. (a) FEB 7 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb. day 5th year 1946 hour 12:40 minute A M.
21. I hereby certify that I attended the deceased from 1/31/46, 19, to 2/5/46, 19; that I last saw him alive on 2/5/46, 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Delirium tremens
Due to
Alcoholism
Due to
Other conditions (Include pregnancy within 3 months of death) Arteriosclerotic Heart Disease
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 Philip F. D. Sutter M.D. (M.D. or other)
Address 1515 Lafayette Date signed 2/5/46

(Licensed Embalmer's Statement on Reverse Side)

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 Robert L. Drinkman

Licensed Embalmer No. 3553

P. O. Address.....

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.