

v. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18581**
Registrar's No. **4880**

FILED JUN 6 1946
318

Registration District No. _____ Primary Registration District No. **1003**

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 **000**

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

(d) Street No. **4646 A EASTON AV.**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **THOMAS M. KENNELLY**

3. (b) If veteran, name war **NO**

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 **BESSIE KENNELLY**

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

7. Birth date of deceased **APRIL 17 1870**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **30**
year **1946** hour **11** minute **55 A.M.**

21. I hereby certify that I attended the deceased from **10:00** **46 May 30 1946**
to **11:17** **46 May 31 1946**
that I last saw him alive on **May 31 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Duration _____

8. AGE:

Years	Months	Days	If less than one day
76	1	13	_____ hr. _____ min.

Due to _____

Due to _____

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

9. Birthplace **MINNESOTA**
(City, town, or county) (State or foreign country)

10. Usual occupation **CARPENTER**

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name **FRANK KENNELLY**

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

14. Maiden name **MARY UNKNOWN**

15. Birthplace **MINN.**
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant **Mrs Bessie Kennelly**

(b) Address **4646 A Easton Av**

17. (a) **BURIAL** (b) Date thereof **JUNE 1 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY CEM.**

18. (a) Signature of funeral director **E. J. Schuur**

(b) Address **3125 Lafayette St**

19. (a) **MAY 31 1946**
(Date received local registrar)

(b) Registrar's signature **J. F. Bredek**

While at work? _____

(Specify type of place) _____

(c) Means of injury _____

Signature **Opelle E. Kenney** M. D. or other _____

Address **706 W. Walton** Date signed **5/31/46**

(Licensed Embalmer's Statement on Reverse Side)

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

17459

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.....

Joe B Vollmer

Licensed Embalmer No. *4014*.....

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.