

No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25418**

59504
FILED AUG 31 5 1946

Primary Registration District No. **1003**

Registrar's No. **6649**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.

(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 _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 237

(d) Street No. 1822 Menard (rear) 9
(If outside city or town limits, write "RURAL")
(If rural, give location) 10

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

If yes, name country _____

3. (a) PRINT FULL NAME William Edgar Kennedy

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

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 November 11 1862
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1946 hour 2:20 minute A M.

21. I hereby certify that I attended the deceased from June 26
1946, to July 23 19 46
that I last saw him alive on July 23 19 46
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>8</u>	<u>12</u>	_____ hr. _____ min.

Immediate cause of death
Cerebral hemorrhage
due to Rupture of
Right Lenticulo-
Striate Artery

Due to _____

Due to _____

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

9. Birthplace Unknown Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant John P. Cullinane

(b) Address Public Administrator

17. (a) Burial (b) Date thereof 7-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUL 29 1946 J. F. Bureau
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury _____

23. Signature Albert H. Mader (M. D. or other) _____
Address 1515 Lafayette Ave. Date signed 7/23/46

(Licensed Embalmer's Statement on Reverse Side)

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

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 *Henry M. Brammer*
Licensed Embalmer No. *4200*

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.