No. 2
4-13-40
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 19 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

35987

State File No.

Registration District No. 2 Primary Registration District No. 5014 Registrar's No. 10

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town SAVANNAH (If outside city or town limits, write "RURAL" and name of township).
(c) Name of hospital or institution: Jefferson Township (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 68 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Buchanan
(c) City or town St Joseph Home (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mertha Jane Kennedy
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced M 1
6. (b) Name of husband or wife Ira Petter Kennedy
6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased JAN (Month) 27 (Day) 1878 (Year)

8. AGE: Years	Months	Days	If less than one day
68	9	7	hr. min.

9. Birthplace Fillmore (City, town, or county) Mo (State or foreign country)
10. Usual occupation practical nurse
11. Industry or business
FATHER
12. Name Phillip Reid DAVISON
13. Birthplace Andrew Co (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name SARAH MESSICK
15. Birthplace Andrew Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant Ira P. Kennedy
(b) Address Savannah Mo
17. (a) B. (Burial, cremation, or removal) (b) Date thereof 11-6-1946 (Month) (Day) (Year)
(c) Place: burial or cremation Fillmore Mo
18. (a) Signature of funeral director E. C. Greer
(b) Address Savannah Mo
19. (a) 11-5-46 (Date received local registrar) (b) Tillery Sparks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 4 year 1946 hour 4 minute 45 A. M.
21. I hereby certify that I attended the deceased from 3 Sept, 1946, to 11-4, 1946 that I last saw her alive on 11-2, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	6 days
Due to Hypertension	unknown
Due to Coronary Heart Disease	unknown
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

94A

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 Lowell Chong (M. D. or other) M.D.
Address Savannah Mo. Date signed 11-4-46

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 E. C. Brecit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.