

FILED JAN 7 1947
Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Smiley Lutheran Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 2 days
(Specify whether years, months or days)

In this community 1 week

3. (a) PRINT FULL NAME John Franklin Lennon

3. (b) If veteran, name war v no

3. (c) Social Security No. 229-10-9688

4. Sex Male 5. Color or race W.

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

6. (b) Name of husband or wife Cora H. Lennon

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Dec. 25 1878
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>11</u>	<u>29</u>	hr. min.

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

10. Usual occupation President of Fidelity Co

11. Industry or business Real Estate & Loans

12. Name John F. Lennon

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

14. Maiden name Margaret Rong

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

16. (a) Informant Mrs Cora H. Lennon

(b) Address 2015 W. 16th Little Rock Ark

17. (a) Removal (b) Date thereof Dec. 24 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Rock Ark

18. (a) Signature of funeral director Mr. C. L. Foster

(b) Address 918 Broadway

19. (a) 12-25-46 (b) Stelaldine Holman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas County Garland ⁹⁹⁹

(c) City or town Little Rock ³
(If outside city or town limits, write "RURAL")

(d) Street No. 2015 W. 16th St.
(If rural, give location)

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

If yes, name country 2

MEDICAL CERTIFICATION

DATE OF DEATH: Month Dec day 24
year 1946 hour 9 minute A. M.

21. I hereby certify that I attended the deceased from Dec. 1946 to 12-24 1946

that I last saw him alive on Dec. 24 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary insufficiency with renal failure Duration 3 weeks

Due to Pneumonia (1 month prior) 8 weeks

Due to Chronic bronchid asthma 10 yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: 1098

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) Day 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 Herbert Stoney (M. D. or other) M.D.
Address 3903 Brooklyn Date signed 12-24-46

MOTHER FATHER

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.....

Signed..... *Conrad Munn*

Licensed Embalmer No. *3414*

P. O. Address..... *918 Brook*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

FILED JAN 17 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5395

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL.")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Franklin Senon
3. (b) If veteran, name was _____
3. (c) Social Security No. 429-10-9688

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 24
year 1946 hour _____ minute _____ M.

4. Sex _____ 5. Color or race _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____
(Month) (Day) (Year)
8. AGE: Years _____ Months _____ Days _____
If less than one day _____ hr. _____ min.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Due to _____
Due to _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)
16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 12-25-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
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? _____ (c) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

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

40703

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.