

FILED DEC 17 1946

Registration District No. 31Primary Registration District No. 6076Registrar's No. 3484

## 1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town Jefferson Barracks  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Veterans Administration Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution Since 12-2-46  
 (Specify whether  
 Unknown  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME KILKENNY, James3. (b) If veteran, name war Spanish-American 3. (c) Social Security No. Unk.4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 4, 1876  
(Month) (Day) (Year)8. AGE: Years 70 Months 7 Days 6 If less than one day  
hr. \_\_\_\_\_ min.9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Clerk

11. Industry or business \_\_\_\_\_

12. Name James Kilkenney13. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)14. Maiden name Ann Gavin15. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)16. (a) Informant Registrar, Vet. Adm. Hospital,(b) Address Jefferson Barracks, Missouri17. (a) Burial (b) Date thereof 12 13 46  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Calvary Cemetery18. (a) Signature of funeral director Kriegshauser Mortuary(b) Address St. Louis, Missouri19. (a) 12-12-46 (b) Ruth Allen  
(Date received local registrar) (Registrar's signature)

## 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. 4355 Hunt Avenue  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 10  
year 1946 hour 12:55 minute \_\_\_\_\_ P. M.21. I hereby certify that I attended the deceased from  
December 2, 1946 to December 10, 1946;  
that I last saw him alive on December 10, 1946;  
and that death occurred on the date and hour stated above.Immediate cause of death CEREBRAL HEMORRHAGE  
WITH HEMIPLEGIA RIGHT; APHASIA AND TRAUMATIC  
PSYCHOSIS Duration \_\_\_\_\_Due to 940  
Due to \_\_\_\_\_Other conditions ARTERIOSCLEROTIC CORONARY  
(Include pregnancy within 3 months of death)  
HEART DISEASEMajor findings: No Operation PHYSICIAN \_\_\_\_\_Of operations \_\_\_\_\_  
Of autopsy No Autopsy  
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) No

(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? No (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_23. Signature E. STILLWELL, M.D. (M. D. or other) \_\_\_\_\_Address Vet. Adm. Hosp., Jeff. Bks., Mo. Date signed 12

JAN 26 1958

**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

*Edwin M. Bennett*

Licensed Embalmer No. *3024*

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.**