. No. 2
—12-45
5-17-39
I X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6535

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2284

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days (Specify whether years, months or days)

In this community

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. 3129 Vinegrove
(If rural, give location)

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

If yes, name country

000
10 17
9
0

3. (a) PRINT FULL NAME Sally Mae Kennedy

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 2

5. Color or race Col

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife Not known

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

7. Birth date of deceased May (Month) 9 (Day) 1897 (Year)

8. AGE: Years 49 Months 9 Days 24 If less than one day hr. min.

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

10. Usual occupation Nil

11. Industry or business

FATHER 12. Name Perry Kennedy /

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

MOTHER 14. Maiden name Jane Leno

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

16. (a) Informant EARL WILLIAMS

(b) Address 3151 S SHERIDAN

17. (a) Shipped (Burial, cremation, or removal) (b) Date thereof MAR 7 1947 (Month) (Day) (Year)

(c) Place: burial or cremation WEST POINT MISS

18. (a) Signature of funeral director E.A. GREEN

(b) Address 2910 FRANKLIN AVE

19. (a) MAR 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 3 year 1947 hour 5 minute 35 P M.

21. I hereby certify that I attended the deceased from 2-19, 1947, to 3-3, 1947; that I last saw her alive on Mar. 3, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Degenerative Heart Disease with Decompensation	Undet.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) None	

Major findings:
Of operations

Of autopsy No

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? (b) Means of injury 0

23. Signature Edw. C. Williams (M. D. or other)

Address 2601 N Whittier Date signed 3/5/47

(Licensed Embalmer's Statement on Reverse Side)

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 J. A. Green

Licensed Embalmer No. 2963

P. O. Address 2915 Franklin

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.