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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19614

State File No. _____
Registrar's No. 1029

Registration District No. 317

Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Marys Hosp. (1)
(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 MO (b) County St. Louis
(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")
(d) Street No. 7238 West Park Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Michael R. Kennedy
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 4 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 hr. _____ min.

9. Birthplace St. Louis Co. Mo. (1)
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Dwight D. Kennedy
13. Birthplace Mo (1)
(City, town, or county) (State or foreign country)
14. Maiden name Rutha Galt
15. Birthplace Mo. (1)
(City, town, or county) (State or foreign country)

16. (a) Informant D. C. Kennedy

(b) Address 939 N. Clay Ave

17. (a) Burial (b) Date thereof May 8 - 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cem.

18. (a) Signature of funeral director: Louis H. Roppae

(b) Address Richmond Heights

19. (a) 5-12-47 (b) Michael R. Kennedy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7
year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from May 4
1947 to May 7 1947;
that I last saw him alive on May 6 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial Hemorrhage causing asphyxia neonatorum
Duration 1 d.

Due to 1600

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

Major findings: 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) 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 Frank A. Bailey (M. D. or other) MD

Address 3108 South Grand Date signed 5-8-47

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.....

Not Embalmed....., 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 with the above constitutes grounds for revocation of license.)

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