FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 26 1947

Registration District No. 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 27758

Registrar's No. 3496

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

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: K. C. Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Gen'l Hos'p #2 (If not in hospital or institution, write street number or location)

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

In this community: 4 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Jackson 48

(c) City or town: K. 1515 Garfield Mo 3 (If outside city or town limits, write "RURAL")

(d) Street No.: 1515 Garfield 8 (If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: Gerry Neal Kennedy

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

3. (c) Social Security No.: no

4. Sex: m 2

5. Color or race: col

6. (a) Single, widowed, married, divorced: no single

6. (b) Name of husband or wife:

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

7. Birth date of deceased: Feb. (Month) 14 (Day) ~~1914~~ 1941 (Year)

8. AGE: 6 Years | 5 Months | 26 Days | If less than one day: hr. min.

9. Birthplace: Norborne Mo (City, town, or county) (State or foreign country)

10. Usual occupation: Child

11. Industry or business:

FATHER
12. Name: Leo Kennedy
13. Birthplace: Hennrietta Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Dollie Morton
15. Birthplace: Whiting Kans, (City, town, or county) (State or foreign country)

16. (a) Informant: Dollie Kennedy

(b) Address: 1515 Garfield

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-15-47 (Month) (Day) (Year)

(c) Place: burial or cremation: ~~Lincoln~~ HIGHLAND

18. (a) Signature of funeral director: Watkins Bros Funeral

(b) Address: 1729 Tyler

19. (a) 8-14-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 10 year 1947 hour 8 minute 55 p.M.

21. I hereby certify that I attended the deceased from Deputy Coroner 19__ to ____, 19__; that I last saw ____ alive on ____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Respiratory Paralysis

Due to: Tetanus

Due to: Head Injury

Other conditions: fell hitting head on pavement (Include pregnancy within 3 months of death)

Major findings:
Of operations: 1860 39

Of autopsy: No - Permit

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): Accident

(b) Date of occurrence: 8-8-47 123

(c) Where did injury occur? K. C. Jackson - Mos (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home - 1515 - Garfield (Specify type of place)

While at work? Play (e) Means of injury: Head

23. Signature: [signature] (M. D. or other) Dr.

Address: 2636 - Brooklyn Date signed: 8-14-47

Jefferson City Printing Co.

(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.....

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.