S. 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 SEP 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30017

Registration District No. 319 Primary Registration District No. 6078 Registrar's No. 53

1. PLACE OF DEATH:

(a) County Ste. Genevieve
(b) City or town Rural Jackson Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
~~R. R. Danby, Missouri~~
(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 Missouri (b) County Ste. Genevieve 95
(c) City or town Rural - Jackson Twp 0
(If outside city or town limits, write "RURAL")
(d) Street No. R. R. Danby 0
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME SMITH M. KENNEDY

3. (b) If veteran, name war ##### 3. (c) Social Security No. #####

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased January (Month) 16 (Day) 1862 (Year)

8. AGE: Years 85 Months 7 Days 8 If less than one day ..... hr. ..... min.

9. Birthplace Ste. Genevieve Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Retired

11. Industry or business .....

FATHER
12. Name Samuel Kennedy 7
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Shumake
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Mrs. Wm. Holst
(b) Address Danby, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/47 (Month) (Day) (Year)
(c) Place: burial or cremation Concord Cem. St. Gen. Co.

18. (a) Signature of funeral director Fink Funeral Parlor
(b) Address Festus, Missouri

19. (a) 8-27-47 (Date received local registrar) (b) Teresa M. Karl Dep (Registrar's signature) 257

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24th year 1947 hour 6 minute 25 P.M.

21. I hereby certify that I attended the deceased from Aug 1, 1947, to Aug 24, 1947, that I last saw him alive on Aug 22, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Apoplexy	3 weeks
Due to: Arterio-Sclerosis	2 yrs.
Due to:	
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature Arthur Eckemann (M. D. or other) MD
Address Ste. Genevieve Mo Date signed 8-25-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

File Number 947-114-1

9-8-47

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 .....

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

working under my personal supervision.

Signed Elena Province

Licensed Embalmer No. 3403

P. O. Address Festus, Missouri

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.