No. 2
-1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 29 1947

Registration District No. 42

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30433

Primary Registration District No. 1000

Registrar's No. 1125

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Methodist Hosp 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 5 days (Specify whether years, months or days)
In this community: 29 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan 11
(c) City or town: St. Joseph 1
(If outside city or town limits, write "RURAL")
(d) Street No.: 324 East Highland 7
(If rural, give location) 0
(e) Citizen of foreign country?: No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Benjamin A. Kennedy
3. (b) If veteran, name war: No
3. (c) Social Security No.: Unknown
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married 1
6. (b) Name of husband or wife: Bessie Kennedy
6. (c) Age of husband or wife if alive: 67 years
7. Birth date of deceased: September (Month) 22 (Day) 1876 (Year)

8. AGE:

Years	Months	Days	If less than one day
70	11	26	hr. min.

9. Birthplace: Brown County (City, town, or county) Kansas (State or foreign country) 1
10. Usual occupation: Carpenter
11. Industry or business: Carpenter
FATHER
12. Name: John Kennedy 4
13. Birthplace: Unknown (City, town, or county) Scotland (State or foreign country) 1
MOTHER
14. Maiden name: Margaret Charlton
15. Birthplace: Unknown (City, town, or county) Canada (State or foreign country) 2
16. (a) Informant: Mrs. Bessie Kennedy
(b) Address: St. Joseph, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/20/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park
18. (a) Signature of funeral director: Keaton-Bowman
(b) Address: St. Joseph, Mo
19. (a) 9-22-47 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 18 year 1947 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept 13 1947 to Sept 18 1947 that I last saw him alive on Sept 18 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemmorhage	6 days
Due to	
Due to	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 83 A
Of autopsy: no autopsy

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):
(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) 0
While at work?: (e) Means of injury:

23. Signature: L. E. Mellney (M. D. or other) MD
Address: 214 Kirkpatrick Bld St Joseph Mo Date signed Sept 19-47

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 Francis J. Wyland Jr. Registered Apprentice No. 444 working under my personal supervision.

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 3196 10th St Joseph MO

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.