

Registration District No. **147**

Primary Registration District No. **5567 4237**

Registrar's No. **277**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Raytown**
 (c) Name of hospital or institution **W.S. & S. Hadley**
 (d) Length of stay: In hospital or institution **6 years**
 In this community **6 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
 (c) City or town **Raytown**
 (d) Street No. **63rd + Hadley**
 (e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Rudolph Hamilton Kenagy**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Carole Kenagy** 6. (c) Age of husband or wife if alive **88** years
 7. Birth date of deceased **Mar. - 19 - 1849**

8. AGE: Years **98** Months **1** Days **4** If less than one day

9. Birthplace **West Liberty, Ohio**

10. Usual occupation **Retired Supv. of Bldg. & grounds**

11. Industry or business **Hamensburg State Teachers College**

12. Name **John H. Kenagy**

13. Birthplace **Millin County, Penn.**

14. Maiden name **Estelle Zoder**

15. Birthplace **Millin Co., Penn.**

16. (a) Informant **E. Lee Kenagy**

(b) Address **Raytown Mo.**

17. (a) Removal **Removal** (b) Date thereof **Dec 26, 1947**

(c) Place: burial or cremation **Hamensburg Mo.**

18. (a) Signature of funeral director **E. Clark Stogert**

(b) Address **Raytown Mo.**

19. (a) **12/26/47** (b) **Michael Harv**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **28** year **1947** hour **Two** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Dec - 1947** to **12-28-1947**
 that I last saw him alive on **12-22-1947**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Empyema of R. Lung**
acute dilatation of heart
following fall.
 Due to **Cardiac Decomposition**
secondary
fell 10/3/47 break-
ing head of R. Femur.

Major findings: **1868**
 Of operations
 Of 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) **48**
 (b) Date of occurrence
 (c) Where did injury occur?
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 (e) While at work? (Specify type of place)
 (f) Means of injury
 23. Signature **Charles Coran** (M.D. or other)
 Address **Raytown Mo.** Date signed **12/24/47**

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

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.....
Charles Stickney..... Registered Apprentice No. *64*
working under my personal supervision.

Signed.....

Clark Regent

Licensed Embalmer No. *3983*

P. O. Address.....

Raytown, 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.

Registration District No. 147

Primary Registration District No. 4237

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Raytown
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Rudolph H. Kenagy

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 m

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

7. Birth date of deceased Nov-19-1908
(Month) (Day) (Year)

8. AGE: Years 98 Months _____ Days _____
If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country) Ohio

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1947 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ and that death occurred on the date and hour stated above.
(Immediate cause of death) _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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

(a) Tell on home 6:30 a.m.

(b) Date of occurrence Dec 7 1947

(c) Where did injury occur? Getting out of bed.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home - Fracture of head R. femur.
(Specify type of place)

While at work _____ (e) Means of injury _____

23. Signature Phedore Longano (M. D. or other) _____
Date signed 3-11-48
Raytown

SUPPLEMENTARY

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

MOTHER, FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

1941 - 1942
Census - Do

12

44298