

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10261**
Registrar's No. **2551**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Faith Hospital		d. STREET ADDRESS (If rural, give location) 4403 Richard Pl.	

3. NAME OF DECEASED (Type or Print) CATHERINE	a. (First)	b. (Middle)	c. (Last) KENNEDY	4. DATE OF DEATH (Month) (Day) (Year) Mar. 20 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED; (Specify) Widow	8. DATE OF BIRTH June 30, 1870	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 8 Days 20	IF UNDER 24 HRS. Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Thomas McDonald	13b. MOTHER'S MAIDEN NAME Catherine Pagan	14. NAME OF HUSBAND OR WIFE Late John W. Kennedy
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME J. V. Kennedy	ADDRESS 4403 Richard Pl.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-vascular heart disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) 72		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 11/20/48			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **3-9-49**, 19___, to **3-20-49**, 19___, that I last saw the deceased alive on **3-20-49**, 19___, and that death occurred at **3:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Anthony V. Benincasa MD	23b. ADDRESS 6153^d Natural Bridge	23c. DATE SIGNED 3/21/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar 23, 1949	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. MAR 21 1949	REGISTRAR'S SIGNATURE J. B. Fawcett	25. FUNERAL DIRECTOR'S SIGNATURE Kriegshausler	ADDRESS 4228 S. Kingshighway Bl.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

61532 North Bridge
1:30 - 4

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Edwin A. McIlernath

Signed _____
Student Embalmer

Licensed Embalmer No. 3024

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.