

FILED JUL 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22236

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>323</u>		PRIMARY REG. DIST. NO. <u>4474</u>		Registrar's No. <u>25</u>	
1. PLACE OF DEATH a. COUNTY <u>SALINE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>SALINE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>SWEET SPRINGS</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>SWEET SPRINGS</u>		d. STREET ADDRESS (If rural, give location) <u>206 So. Saline St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>206 So. Saline</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 5 49</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>REBECCA</u>		b. (Middle) <u>ANNIE</u>		c. (Last) <u>KENNEDY</u>		5. SEX <u>FEMALE</u>	
6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>		8. DATE OF BIRTH <u>OCT. 7-1868</u>		9. AGE (In years last birthday) <u>80</u> if UNDER 1 YEAR: Months <u>8</u> Days <u>28</u> if UNDER 24 HRS. Hours <u>_____</u> Min. <u>_____</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>CARROLTON, ARK.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>REV. U.A. WALDEN</u>		13b. MOTHER'S MAIDEN NAME <u>SELEMMMA ANN MAXWELL</u>		14. NAME OF HUSBAND OR WIFE <u>JOSEPH L. KENNEDY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Margaret Kennedy</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Cardiac decompensation</u> ANECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>NYX</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) _____		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? _____					
22. I hereby certify that I attended the deceased from <u>Sept 19 47</u> to <u>July 3, 1949</u> , that I last saw the deceased alive on <u>July 3, 1949</u> , and that death occurred at <u>2:00 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Joseph P. Doyle M.D.</u>				23b. ADDRESS <u>Sweet Springs, Mo</u>		23c. DATE SIGNED <u>July 6, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>7-7-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>SWEET SPRINGS MO</u>	
DATE REC'D BY LOCAL REG. <u>7/6/49</u>		REGISTRAR'S SIGNATURE <u>Dolly Andrews</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. Parker</u>		ADDRESS <u>Sweet Springs Mo</u>	

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

97
63
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RECEIVED JUL 12
District Health Officer No. 8,
District File Number _____
Date Filed 7-13-49

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 _____

L. F. Tasker

Signed _____
Student Embalmer

Licensed Embalmer No. 3840

P. O. Address Sweet Springs, T

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.