

FILED AUG 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22811

State File No.

BIRTH NO. <u>40385-49</u>		REG. DIST. NO. <u>59</u>	PRIMARY REG. DIST. NO. <u>4097</u>	Registrar's No. <u>118</u>
1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Cass</u>		
b. CITY OR TOWN <u>Harrisonville</u>	c. LENGTH OF STAY (If institution) <u>7 hrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Garden City</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>No Number</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Allen</u> b. (Middle) <u>Lynn</u> c. (Last) <u>Kenagy</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 8-49</u>		
5. SEX <u>M.</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>Aug 7-49</u>	9. AGE (In years last birthday) <u>-</u> MONTHS <u>-</u> DAYS <u>-</u> HOURS <u>-</u> MIN. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Chas A. Kenagy</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Reynolds</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, state year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Chas Kenagy</u> ADDRESS <u>Garden City</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>congenital heart disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>7544</u>
19a. DATE OF OPERATION <u>-</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>-</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>- - -</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>- - -</u> m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>- - -</u>		
22. I hereby certify that I attended the deceased from <u>8-7-</u> , 19 <u>49</u> , to <u>8-8</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>5 Aug 8-9, 1949</u> , and that death occurred at <u>- - -</u> m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>Edward S. Jones MD</u>		23b. ADDRESS <u>Harrisonville, MO</u>		23c. DATE SIGNED <u>8-8-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 8-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Garden City</u>	24d. LOCATION (City, town, or county) (State) <u>Garden City MO</u>	
DATE REC'D BY LOCAL REG. <u>Aug 8, 1949</u>	REGISTRAR'S SIGNATURE <u>Laura J. Jones</u>	51	25. FURNITURE DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Garden City MO</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. _____

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.

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