S. No. 300
v. 10.48

FILED MAY 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14762

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3733

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St.Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of The Poor 3400 S.Grand Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St.Louis 16 2169
d. STREET ADDRESS (If rural, give location) 3400 S.Grand Blvd.

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle)
c. (Last) Mc Kenna

4. DATE OF DEATH (Month) April (Day) 21, (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH May 15,1872
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR: Months 11 Days 7 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Mc Kenna
13b. MOTHER'S MAIDEN NAME Margaret Hagen
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Sister Henry **ADDRESS** 3400 S.Grand Blvd.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio-Sclerotic Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ch. Gl. Nephritis — 2 yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr 7, 1949, *to* Apr 21, 1950, *that I last saw the deceased alive on* Apr 20, 1950, *and that death occurred at* 2, A m., *from the causes and on the date stated above.*

23a. SIGNATURE Edw. J. Bailey M.D. (Degree or title) **23b. ADDRESS** 607 Ko Grand **23c. DATE SIGNED** 4-25-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 4/25/50
24c. NAME OF CEMETERY OR CREMATORY St.Peter&Paul Cemetery
24d. LOCATION (City, town, or county) St.Louis (State) MO.

DATE REC'D BY LOCAL REG. APR 24 1950
REGISTRAR'S SIGNATURE J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons **ADDRESS** 2630 Gravois Ave

(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 Robert F Gebkin

Licensed Embalmer No. 444

P. O. Address 2630 Gravois a

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.