

FILED FEB 12 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

246

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 113

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	
c. LENGTH OF STAY (In this place) <u>60 yrs</u>		0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>435 North 17th St.</u>		d. STREET ADDRESS (If rural, give location) <u>435 North 17th St.</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>Lyda</u>	b. (Middle) <u>Emaline</u>	c. (Last) <u>Kennard</u>	Feb. 4		1951
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>Sept. 11, 1882</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Dr. J. H. Sampson</u>	13b. MOTHER'S MAIDEN NAME <u>Josephine Parnell</u>	14. NAME OF HUSBAND OR WIFE <u>George Kennard</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>Ralph S. Kennard</u> ADDRESS <u>435 1/2 N. 17th St. Joseph</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		INTERVAL BETWEEN ONSET AND DEATH  <u>2 wks</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial insufficiency</u>		
	ANTECEDENT CAUSES Morbidity 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.		<u>4222</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 2/8, 1951, to 2/4, 1951, that I last saw the deceased alive on 2/4, 1951, and that death occurred at 2:50 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Scott C. Benson</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>202 Phys. &amp; Surgeons</u>	23c. DATE SIGNED <u>2/15/51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>2/7/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Mora</u>
24d. LOCATION (City, town, or county) (State) <u>St. Joseph Missouri</u>		

DATE REC'D BY LOCAL REG. <u>Feb. 6, 1951</u>	REGISTRAR'S SIGNATURE <u>Carl C. Casler</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Victor Bauerman</u> ADDRESS <u>Funeral Home St Joseph Mo</u>
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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.

Signed W E Edmonstone.....

Signed.....  
Student Embalmer

Licensed Embalmer No. 4791

P. O. Address 319 So 10 St Wash

**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.