

FILED MAY 4 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14331  
3785

318

1003

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

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	
c. LENGTH OF STAY (in this place) 4-days		2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If rural, give location) 7 5204 Gilmore Ave.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) Minnie			b. (Middle) Kennedy				
c. (Last) Kennedy			Apr. 20, 1951				
5. SEX F	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W.	8. DATE OF BIRTH Sept. 29, 1883	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 6	IF UNDER 11 HRS. Days 21	IF UNDER 1 MIN. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Mattahias Tecklenburg		13b. MOTHER'S MAIDEN NAME Mary A. Cramer		14. NAME OF HUSBAND OR WIFE Mr. Edward Kennedy	
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. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Katherine Geiss, 4160 Botanical Ave.	

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) <i>Carotid Arteriosclerosis</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <i>Chronic Glomerulonephritis</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS. <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>3 yrs</i>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>592X</i>	

22. I hereby certify that I attended the deceased from *4-18*, 19*51*, to *4-20*, 19*51*, that I last saw the deceased alive on *4-20*, 19*51*, and that death occurred at *10:30 AM*, from the causes and on the date stated above.

23a. SIGNATURE <i>Arthur J. Donnelly</i>		23b. ADDRESS <i>in D HAS Maryland</i>		23c. DATE SIGNED <i>4-23-51</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>Apr. 24, 1951</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	
24d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>		FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Donnelly</i>		ADDRESS <i>3840 Lindell Blvd.</i>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <i>APR 23 1951</i>		REGISTRAR'S SIGNATURE <i>J. B. Kasater</i>		FUNDING AGENCY'S SIGNATURE	

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

*Handwritten notes at the top of the page, possibly including a name and date.*

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.....

*W. H. VanMatre*

Licensed Embalmer No. *2820*

P. O. Address *4340 Lafayette*

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.