

AUG 15 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29669

State File No. _____

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7219			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY 2179					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 1		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 17 4618 Tower Grove Pl.			
d. FULL NAME OF HOSPITAL OR INSTITUTION 4618 Tower Grove Pl.				d. STREET ADDRESS (If rural, give location)					
3. NAME OF DECEASED (Type or Print)		a. (First) JOHN		b. (Middle) L.		c. (Last) KENNEDY			
4. DATE OF DEATH		(Month) July		(Day) 26		(Year) 1952			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 28, 1872			
9. AGE (In years last birthday) 80		10. UNDER 1 YEAR 0		11. UNDER 1 HRS 0		12. UNDER 1 MIN. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy (Retired) United States Marshall				10b. KIND OF BUSINESS OR INDUSTRY United States Marshall		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.			
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME Edward Kennedy		13b. MOTHER'S MAIDEN NAME Ellen Quigley		14. NAME OF HUSBAND OR WIFE Margaret F. 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. _____		17. INFORMANT'S SIGNATURE OR NAME Margaret F. Kennedy ADDRESS 4618 Tower Grove					
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.		<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis</p> <p>ANTECEDENT CAUSES</p> <p>Asorbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) Arterio Sclerosis</p> <p>DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p>						INTERVAL BETWEEN ONSET AND DEATH 5 days 6 yrs	
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) _____			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4201							
22. I hereby certify that I attended the deceased from July 21, 1952 , to July 26, 1952 , that I last saw the deceased alive on July 26, 1952 , and that death occurred at 9:20 A.M. , from the causes and on the date stated above.									
22a. SIGNATURE (Degree or title) Thornton Greener, M.D.				22b. ADDRESS 4500 Olive St		22c. DATE SIGNED 7/26/52			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 28, 1952		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. JUL 28 1952		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		24. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser ADDRESS 4228 S. Kingshighway Bl.					

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

(Licensed Embalmer's Statement on Reverse Side)

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 Richard W. Storvick

Licensed Embalmer No. 4007

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.