

FILED OCT 26 1954

STANDARD CERTIFICATE OF DEATH
318

1003

State File No. 35561
Registrar's No. 8798

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 MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS,		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN ST LOUIS,		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 5933 ERA AVE				e. STREET ADDRESS (If rural, give location) 5933 ERA AVE 20790			
3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH		b. (Middle) S.		c. (Last) KENNEY		4. DATE OF DEATH (Month) (Day) (Year) SEPT, 26, 1954	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH APRIL 15, 1895	
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED POSTAL WORKER		11. BIRTHPLACE (City and State or Foreign Country) ST LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOHN KENNEY		13b. MOTHER'S MAIDEN NAME MARY FITZPATRICK		14. NAME OF HUSBAND OR WIFE MARY KENNEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or title of service) YES		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MARY KENNEY 5933 ERA 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) Coronary Thrombosis INDEPENDENT CAUSES DUE TO (b) Coronary Insufficiency DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not relating to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH None 3 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 May 3, 1953, to Aug 4, 1954, that I last saw the deceased alive on Aug 4, 1954, and that death occurred at 8 P.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Blue G McJorney MD				23b. ADDRESS 5014 Threlka Av		23c. DATE SIGNED 9/27/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 9/30/54		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		24d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI	
DATE REC'D BY LOCAL REG. SEP 27 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE			

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

OCT 26 1914

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.....
Signature of Student Embalmer

Signed M. W. Ruter.....

Licensed Embalmer No. 486

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.