

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43330

State File No. ....

5419

FILED JAN 18 1956

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City Mo 412440</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hos. St. Joseph Hosp.</u>				STREET ADDRESS (If rural, give location) <u>3718 Flora Ave</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Vassie</u>		b. (Middle) <u>M.</u>		c. (Last) <u>Kennedy</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 12 55</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, 2 WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec 3 1886</u>			
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>					
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 _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13a. FATHER'S NAME <u>Miller &amp; Roberts</u>		13b. MOTHER'S MAIDEN NAME <u>Lucinda Dyer</u>			
14. NAME OF HUSBAND OR WIFE <u>Frank Kennedy</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>Lela May Kennedy</u>				ADDRESS <u>Kansas City</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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pending Microscopic Examination</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>lower nephron nephrosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Severe Ch. Rheumatoid Arthritis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>591X</u>	
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) (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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, or that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE H. Frank Holman (Degree or title) <u>MD</u>				23b. ADDRESS <u>St Joseph Hosp.</u>		23c. DATE SIGNED <u>12-12-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 15 '55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cr.</u>		24d. LOCATION (City, town, or county) (State) <u>7 mi. S of Higginsville Mo.</u>			
DATE REC'D BY LOCAL REG. <u>12-13-55</u>		REGISTRAR'S SIGNATURE <u>newa minshall</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Forest Ricketts</u> ADDRESS <u>Higginsville Mo.</u>					

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.....  
Signature of Student Embalmer

Signed *Forest W. Rickhof*.....

Licensed Embalmer No. *128*.....

P. O. Address *Higgins*.....

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.