

FILED JAN 23 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **1214**BIRTH NO. _____ REG. DIST. NO. **140** PRIMARY REG. DIST. NO. **3024** Registrar's No. **4**

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, write RURAL and give town) Fayette, Mo.		c. LENGTH OF STAY (in this place) 3 yrs.	c. CITY OR TOWN Fayette
d. FULL NAME OF HOSPITAL OR INSTITUTION 107 Reynolds		STREET ADDRESS (If rural, give location) 107 Reynolds	

3. NAME OF DECEASED (Type or Print) a. (First) Roger	b. (Middle) Mack	c. (Last) Kendrick	4. DATE OF DEATH (Month) (Day) (Year) Jan. 5, 1956
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 2, 1910	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months 10 Days 3	IF UNDER 24 HRS. Hours Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator	10b. KIND OF BUSINESS OR INDUSTRY City Water Plant	11. BIRTHPLACE (City and State or Foreign Country) Howard County, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James P. Kendrick	13b. MOTHER'S MAIDEN NAME Mary Belle McFall	14. NAME OF HUSBAND OR WIFE Leta Louise Walkup
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 487-18-1410	17. INFORMANT'S SIGNATURE OR NAME Mrs Roger Mack Kendrick Fayette, Mo.	ADDRESS Fayette, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shot - Gun Wound of Skull - (Compound comminuted fracture of skull) (self inflicted)	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 976x	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			

21a. ACCIDENT SUICIDE OR HOMICIDE (Specify) Suicide	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Fayette Howard Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1-5-56	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Self inflicted gun shot wound

22. I hereby certify that I attended the deceased from **1-5**, 19**56** to **1-5**, 19**56** that I last saw the deceased alive on **Jan**, 19, and that death occurred at **11** m., from the causes and on the date stated above.

23a. SIGNATURE W. Blom	(Degree or title) M.D.	23b. ADDRESS	23c. DATE SIGNED 1-9-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1/8/1956	24c. NAME OF CEMETERY OR CREMATORY Walnut Grove Cemetery	24d. LOCATION (City, town, or county) (State) Armstrong, Missouri
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DATE REC'D BY LOCAL REG. 1-9-56	REGISTRAR'S SIGNATURE Mary K. Shell	430	25. FUNERAL DIRECTOR'S SIGNATURE Ralph A. Carr	ADDRESS Fayette, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

194 25 1950

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, ~~only~~, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Ralph A. Carr*.....

Licensed Embalmer No. *33*

P. O. Address *Gayette*

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.