

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42599

STATE FILE NUMBER

90405-56
FILED JAN 10 1957

Registration District No. 316 Primary Registration District No. 6074 Registrar's No. 452

1. PLACE OF DEATH a. COUNTY St. Francois			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Randolph Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Bonne Terre Rt. 1		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rt. 1 Bonne Terre		Length of stay in lb 5 da.	d. STREET ADDRESS (If outside, give location) Route #1.		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Josephene Middle Kay Last Kennon			4. DATE OF DEATH Month Dec. Day 28 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23rd. 1956		9. AGE (In years last birthday) IF UNDER 1 YEAR Months 5 Days 5 IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Farmington, Missouri	
13. FATHER'S NAME Clarence C. Kennon			14. MOTHER'S MAIDEN NAME Margaret Ethel Mason		
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 Address Terre, Clarence C. Kennon, Rt. 1 Bonne Ma.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute fulminating lobar Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) unknown DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Baby born dead in Out about 6:30 AM - alive with 2:00 AM - 76 30					INTERVAL BETWEEN ONSET AND DEATH 2-3 hours
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Coroner - notified			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 4:00 a m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) MCA Rohlfing M.D.			22b. ADDRESS 41st Power Mo		22c. DATE SIGNED 12/28/56
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/30/56	23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		23d. LOCATION (City, town, or county) (State) St. Francois Co. Mo
24. FUNERAL DIRECTOR Boyer Funeral Home		ADDRESS Desloge, Mo		25. DATE RECD. BY LOCAL REG. 12-28-56	26. REGISTRAR'S SIGNATURE Ether Rudloff

Health, Welfare, Public Service
300-56
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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.....

Licensed Embalmer No. 36

P. O. Address Declo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
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.