

Health,  
& Welfare  
Public  
Service

FILED MAY 20 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16245  
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 448

S. 300  
1-57  
0

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|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Greene</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Springfield</b>              |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>Springfield</b> <b>0396</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Burge Hospital</b> |  | Length of stay in lb<br><b>40 Yrs.</b>  | d. STREET ADDRESS (If outside, give location)<br><b>Sterling Hotel</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>DAVID ROLLAND KENNEDY Sr.</b> |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>May 10, 1957</b> |  |  |
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|                    |                               |   |   |   |  |                                 |
|--------------------|-------------------------------|---|---|---|--|---------------------------------|
| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>22 Jan. 1889</b> | 9. AGE (In years)<br><b>68</b> (birthday) | 10. UNDER 1 YEAR<br>Months Days Hours Min. | 11. UNDER 24 HRS.<br>Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mail Carrier</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b> | 11. BIRTHPLACE (City and state or country)<br><b>Missouri</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
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| 13a. FATHER'S NAME<br><b>H. F. Kennedy</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Love Appleby</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Deceased</b> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No No No</b> | 16. SOCIAL SECURITY NO.<br><b>No</b> | 17. INFORMANT<br><b>Hospital Records</b><br>Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia, acute</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 Days</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Emphysema &amp; Bronchiectasis</b> | <b>Years</b>  |
|   | DUE TO (c)                                       |   |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                               |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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| 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.)<br><b>5271</b> |
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| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m.<br>p.m. | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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<br>COUNTY STATE |
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| 21. I attended the deceased from <b>4 Dec. 1951</b> to <b>10 May 1957</b> and last saw him alive on <b>9 May 1957</b><br>Death occurred at <b>3:25 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated. |  |
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| 22a. SIGNATURE<br><b>James E. Druff M.D.</b> (Degree or title) | 22b. ADDRESS<br><b>1630 N. Jefferson Springfield, Missouri</b> | 22c. DATE SIGNED<br><b>5/10/57</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>5-11-57</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bellview</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Greene County, Mo.</b> |
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| 24. FUNERAL DIRECTOR<br><b>J.W. Klingner &amp; Co. Spgfd. Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>5-15-57</b> | 26. REGISTRAR'S SIGNATURE<br><b>Edna Williams</b> |
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(Licensed Embalmer's Statement on Reversed Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

APR 10 1956

APR 27 1956

JUN 28 1957

MS  
APR 20 1959

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 *Max F. ...*

Licensed Embalmer No. 467

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.