

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33717

FILED SEP 17 1957

STATE FILE NUMBER  
8140

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE No. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Length of stay in 1b 3 days	
3. NAME OF DECEASED (Type or print) First Middle Last James William Kendall		4. DATE OF DEATH Month Day Year Aug. 29, 1957	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Elec. Eng.		10b. KIND OF BUSINESS OR INDUSTRY Potter Elec. Co.	11. BIRTHPLACE (City and state or country) Kenton Co., Kentucky
13. FATHER'S NAME Kendall		14. MOTHER'S MAIDEN NAME Elizabeth Stansifer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 491-18-0849	17. INFORMANT Mrs. Lulu A. Kendall
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMOCOCCAL LOBAR PNEUMONIA Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) 490X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 3-4 DAYS
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
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		20g. STATE	
21. I attended the deceased from 8/27/57 to 8/29/57 and last saw her/him alive on 8/29/57 Death occurred at 10:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) William A. Tully M.D.		22b. ADDRESS 3720 WASHINGTON	
22c. DATE SIGNED 8/29/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Aug. 30, 1957	
23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR Alexander & Sons 6125 Delmar		25. DATE RECD. BY LOCAL REG. AUG 30 '57	
		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

*Dr. Fables*  
*3720 Washington*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *Gas E McCallan*

Licensed Embalmer No. *240*

P. O. Address *H. Lane*

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