

Dept. Health,
uc., & Welfare
J. S. Public
Health Service

FILED DEC 13 1957

STANDARD CERTIFICATE OF DEATH

42207

Registration District No. 318 Primary Registration District No. 1003 STATE FILE NUMBER 11704 Registrar's No.

V. S. 300
Rev. 1-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 5370 Pershing Ave	
3. NAME OF DECEASED (Type or print) First James Middle Kennedy Last			4. DATE OF DEATH Month December Day 4 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 18, 1893	9. AGE (In years last birthday) 64 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jewelry Manf.		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
13a. FATHER'S NAME Alexander Charles Kennedy		13b. MOTHER'S MAIDEN NAME Genevieve Pasquer		14. NAME OF HUSBAND OR WIFE	
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. 492-09-7060		17. INFORMANT Address Miss Katherine T. Kennedy #4 Algonquin Lane	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach				INTERVAL BETWEEN ONSET AND DEATH 1 year	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 151X					
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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <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 July 1956 to 12/3/57 and last saw ^{her} him alive on 12/3/57 . - Death occurred at 8:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Fau Sauls M.D.			22b. ADDRESS 7870 Carondelet		22c. DATE SIGNED 12/4/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/7/57	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo
24. FUNERAL DIRECTOR Alexander & Sons ADDRESS 6175 Delmar Blvd			25. DATE RECD. BY LOCAL REG. DEC 5 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith mo m8B

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Securing the nearest curriculum in the specific manner required by 193.140 MoRS 1947.

Dr. Dean Sauer
Deaconess Hospital
Vo. 3-6300

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 *Jos. E. McCulloch*

Licensed Embalmer No. *2460*
P. O. Address *6175 Alma*

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.