

1934

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED FEB 3 1958

STATE FILE NUMBER 9

Registration District No. 182 Primary Registration District No. 3687 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY OR TOWN <u>Grantsville Township</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.F.D.# 3</u> Length of stay in 1b <u>85 years</u>		d. STREET ADDRESS (If outside, give location) <u>Grantsville, Twnap</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Isaac Leroy Kennedy</u>			4. DATE OF DEATH Month Day Year <u>January 22 1958</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1871</u>
9. AGE (In years) <u>86</u> Months <u>2</u> Days <u>10</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Linn County, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>William Henry Kennedy</u>	
13b. MOTHER'S MAIDEN NAME <u>Louisa Jane Cline</u>		NAME OF HUSBAND OR WIFE <u>Clara Kennedy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-42-4762</u>	17. INFORMANT Address <u>J. B. Kennedy, Brookfield, Missouri</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 da.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>multiple stroke syndrome, arterio-sclerosis</u>			<u>2 yr.</u>
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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>334X</u>	
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 COUNTY STATE
21. I attended the deceased from <u>Nov. 21st, 1955</u> to <u>Jan. 22/58</u> and last saw ^{him} alive on <u>Jan. 22, 1958</u> Death occurred at <u>9:35 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John Otis Carr D.O.</u>		22b. ADDRESS <u>124 W. Ritchie, Marceline</u>	22c. DATE SIGNED <u>1/24/58</u>
23a. BURIAL, CREATION, REMOVAL (Specify)	23b. DATE <u>Jan. 25, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>J. W. Blacklock, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 25-1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Birdie Kelley</u>

(Licensed Embalmers' Statement on Reverse Side)

 health,
 Welfare
 Public
 Service
300
-57
 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.

 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

MAR 13 1958

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 *Gerald F Wade*

Licensed Embalmer No. *4172*
P. O. Address *Brown*

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.