

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019853

STATE FILE NUMBER 5593

FILED JUN 11 1958

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

00
57

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		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3021 Allen Ave		Length of stay in lb Life	
d. STREET ADDRESS 3021 Allen Ave		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALIDA NINETTE KENN			4. DATE OF DEATH Month Day Year May 27, 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1896
9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. Month Days Hours Min. 62		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinster	
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Hervey Kent	
13b. MOTHER'S MAIDEN NAME Clara Sebastian		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give year or dates of service) No none		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Cora Kent		Address 3021 Allen	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer from undetermined site Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (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)			INTERVAL BETWEEN ONSET AND DEATH Four months 199.2
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 COUNTY STATE	
21. I attended the deceased from 3/14/58 to 58 and last saw her alive on 3/19/58 Death occurred at May 27, at 3:58 pm on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James A. Nutschman M.D.		22b. ADDRESS 114 W Taylor	
22c. DATE SIGNED 5/28/58		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 29, 1958	
23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar		25. DATE RECD. BY LOCAL REG. MAY 28 '58	
26. REGISTRAR'S SIGNATURE J. Paul Smith M.D. S.P.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. James M Hutchanson
Grant Med Clinic

X

DATE OF DEATH: _____

TIME OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

SEX: _____

RACE: _____

AGE: _____

HT: _____

WT: _____

HAIR: _____

EYES: _____

RELIGION: _____

EDUCATION: _____

OCCUPATION: _____

RESIDENCE: _____

DECEASED: _____

EMERALD: _____

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 Joe E. McCulloh
Licensed Embalmer No. 2461
P. O. Address 6175 Dell

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.