

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025598

STATE FILE NUMBER

FILED JUL 17 1958

Registration District No. 149 Primary Registration District No. 1007 Registrar's No. 3119

S. 300 D  
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before a. STATE <u>Missouri</u> , b. COUNTY <u>Jackson</u> )					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</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>St. Marys Hosp.</u>			Length of stay in 1b <u>44 Yrs</u>		d. STREET ADDRESS (If outside, give location) <u>1200 E. 11th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MATTIE</u> Middle <u>B</u> Last <u>KENNE</u>				4. DATE OF DEATH Month <u>6</u> Day <u>21</u> Year <u>1958</u>					
5. SEX <u>Female</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>Feb. 7 1883</u>		9. AGE (In years) <u>75</u> (If birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done over a period of life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (City and state or country) <u>Bethany, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Wm. Perry Clark</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah E. Smith</u>			14. NAME OF HUSBAND OR WIFE <u>Clarence A. Kenne</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Clarence A. Kenne 1200 E. 11th.</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>Anemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Lower nephrom nephrosis</u> DUE TO (c) <u>Surgical Shock</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u> <u>2 1/3 months</u> <u>22 Days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute Pancreatitis of Tail &amp; RT Hip Fracture 5-29-58</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT <input checked="" 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>She fell at home</u> <u>E 9:45</u> <u>21</u>						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>5-29-58</u>			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>						
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>			20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>K.C. 123 Jackson Mo</u>			
21. I attended the deceased from <u>5-29-58</u> to <u>6-21-58</u> and last saw her alive on <u>6-21-58</u> Death occurred at <u>3:50 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Dr. Leo A. O'Brien M.D.</u>					22b. ADDRESS <u>306 E 12 - K.C. Mo</u>		22c. DATE SIGNED <u>6-23-58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-24-1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>FLORAL HILLS MEM. CHAPELS, INC</u>				25. DATE RECD. BY LOCAL REG. <u>6-24-58</u>		26. REGISTRAR'S SIGNATURE <u>Steve Mickell</u>			

(Licensed Embalmer's Statement on Reverse Side)

vector, color, 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  
Leo A. O'Brien



*Albion  
Blair  
M*

**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 *A. J. Nofsinger*  
Licensed Embalmer No. *3938*  
P. O. Address *40 No.*

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.