

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032773

STATE FILE NUMBER

4268

FILED SEP 24 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4268

1. PLACE OF DEATH a. COUNTY JACKSON COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY, Mo		c. CITY OR TOWN KANSAS CITY, MISSOURI	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SAINT LUKES		d. STREET ADDRESS 7125 OLIVE	
3. NAME OF DECEASED First Middle Last RALPH VICTOR KENNEDY		4. DATE OF DEATH Month Day Year SEPT. 6 <sup>th</sup> 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 14, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) KANSAS CITY, MISSOURI
13a. FATHER'S NAME JOHN L. KENNEDY		13b. MOTHER'S MAIDEN NAME SARAH CARPENTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) YES WW #1 (ARMY)		16. SOCIAL SECURITY NO. -	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of the Aorta		17. INFORMANT Address MRS. C. A. BETTS - TUSCON, ARIZONA	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		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.)	
20c. TIME OF INJURY . Hour Month, Day, Year 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 Sept 3, 1958 to Sept 6, 1958 and last saw him alive on Sept 6, 1958 Death occurred at 2:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Harold W. Voth, M.D.		22b. ADDRESS 201 Plaza Medical Bldg. 315 N. 7th St. K. C. Mo.	
22c. DATE SIGNED Sept 7, 1958			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE SEPT-7-58	23c. NAME OF CEMETERY OR CREMATORY FOREST HILL	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
24. FUNERAL DIRECTOR ADDRESS D.W. NEWCOMER & SONS. KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 9-7-58	26. REGISTRAR'S SIGNATURE Neva Minshall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Harold W. Voth

Dr. Harold Vath  
St. Louis



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 *Vern Lawler* .....

Licensed Embalmer No. *4915* .....

P. O. Address *KC MO* .....

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.