Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-036455
STATE FILE NUMBER

FILED OCT 29 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4784

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Walnut Nurs. Home — Length of stay in Ib 7 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 40 East 32d St. (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First FLOYD Middle Last KENNEDY
4. DATE OF DEATH Month 10 Day 8 Year 58
5. SEX Ma
6. COLOR OR RACE Wh
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH 5-15-1879
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber
10b. KIND OF BUSINESS OR INDUSTRY Plumbing
11. BIRTHPLACE (City and state or country) Pickering, Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Sam Stockton Kennedy
13b. MOTHER'S MAIDEN NAME Charlotte Murin
14. NAME OF HUSBAND OR WIFE xx
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) xx
16. SOCIAL SECURITY NO. 425-30-265A
17. INFORMANT Address Mrs. Florence Martin, 46 E. 32d, K.C, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH 2 Hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 20 yrs.
(c) Pneumonia. — 2 wks
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 [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 1957, to 1958-10-8 and last saw her alive on 4 July 1958.
Death occurred at 2:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wallace H. Graham, M.D. (Degree or title)
22b. ADDRESS 518 Argyle Bldg.
22c. DATE SIGNED 8 Oct. 1958

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10-13-58
23c. NAME OF CEMETERY OR CREMATORY Mt. Washington
23d. LOCATION (City, town, or county) Kansas City (State) Mo
24. FUNERAL DIRECTOR Wagner Funeral Home. ADDRESS K C Mo
25. DATE RECD. BY LOCAL REG. 10-10-58
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Wallace H. Graham USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

3:30 P.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 Alvin R. Haenschel

Licensed Embalmer No. 4159

P. O. Address R. C. 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.