

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045900

STATE FILE NUMBER

REGISTRATION DISTRICT No. **318** Primary Registration District No. **1003** Registrar's No. **12009**

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,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4213 W. FARLIN AVE		d. STREET ADDRESS (If outside, give location) 4213 W. FARLIN AVE	

3. NAME OF DECEASED (Type or print) First Middle Last THOMAS D. KENNEDY			4. DATE OF DEATH Month Day Year DEC. 12, 1958		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 18, 1870	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) IRELAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT THOMAS J. KENNEDY	Address 4213 W. FARLIN AVE
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction arteriosclerosis arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH golden yellow yes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.	DUE TO (b)	
	DUE TO (c)	420.1
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.)
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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
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21. I attended the deceased from Death occurred at Jan 9 1957 to Dec 12 1958 and last saw him alive on 12-9-58
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22a. SIGNATURE M. C. Spoonemore (Degree or title) M.D.	22b. ADDRESS 4400a - Natural Bridge	DATE SIGNED 12/10/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/15/58	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI
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24. FUNERAL DIRECTOR STROOT - CARROLL	ADDRESS 4600 NATURAL BRIDGE	25. DATE RECD. BY LOCAL REG. DEC 13 58	26. REGISTRAR'S SIGNATURE J. Earl Smith M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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1-57

H-T.

