

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018097

FILED JUN 2 1959 Registration District No. 146 Primary Registration District No. 5568 STATE FILE NUMBER 244 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Blue Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Independence</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rt. 1.</b>		Length of stay in 1b <b>8 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>R. 1</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Adolph</b> Middle <b>Kennedy</b> Last <b>Herndon</b>			4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 3, 1902</b>	9. AGE (In years last birthday) <b>57</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>26</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dental</b>	11. BIRTHPLACE (City and state or country) <b>Maryville, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	

13a. FATHER'S NAME <b>O. K. Herndon</b>		13b. MOTHER'S MAIDEN NAME <b>Frauline Kennedy</b>		14. NAME OF HUSBAND OR WIFE <b>Valyma Herndon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>489-44-3024</b>		17. INFORMANT <b>Valyma Herndon, Rt. 1, Independence, Mo.</b> Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Artery Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Artery Arteriosclerosis</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) <b>332X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 _____ 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.) <b>Independence Jackson Mo</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Independence Jackson Mo</b>	
21. I attended the deceased from <b>1954</b> to <b>1959</b> and last saw him alive on <b>May 25, 1959</b> Death occurred at <b>10:30 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>D. F. Shireman MD</b> (Degree or title)			22b. ADDRESS <b>4606 St John K C Mo</b>		22c. DATE SIGNED <b>5-26-59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-29-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>	
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24. FUNERAL DIRECTOR <b>Stine &amp; McClure, Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-28-59</b>		26. REGISTRAR'S SIGNATURE <b>James L. Davis</b>	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *William M. Turner*

Licensed Embalmer No. *4048*  
P. O. Address *Lawson City, 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.