

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019319

STATE FILE NUMBER

Registrar's No. **2 4673**

FILED MAY 26 1959

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Community Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>4110 W. Belle Pl.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES KENNEDY</b>			4. DATE OF DEATH Month Day Year <b>May 10, 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1881</b>		9. AGE (In years last birthday) <b>77</b> 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) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>St. Mary's Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>James Kennedy</b>		13b. MOTHER'S MAIDEN NAME <b>?</b>		14. NAME OF HUSBAND OR WIFE <b>Stella Kennedy</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>489-03-6642</b>		17. INFORMANT Address <b>Stella Kennedy 4110 W. Belle Pl</b>	

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>Complete Heart Block</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis</b>	
	DUE TO (c) <b>433.0</b>	
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK 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 <b>May 1, 59</b> to <b>May 10</b> and last saw her/him alive on <b>May 1, 59</b> Death occurred at <b>May 10 - 4:30A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <b>Walter G. Younge MD</b>	22b. ADDRESS <b>4635 Easton</b>	22c. DATE SIGNED <b>5-11-59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/14/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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24. FUNERAL DIRECTOR <b>Charles J. Gates</b>	ADDRESS <b>4107 Finney</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 13 '59</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Geoffrey Swanson* .....

Licensed Embalmer No. 4580 .....

P. O. Address 4107 Finney Av .....

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.