Dept. Health, Ed., & Welfare U. S. Public Health Service

Form S. 300 Rev. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-020713

STATE FILE NUMBER

FILED JUL 6 1959 Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 56

1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Excelsior Springs — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Veterans Administration Hospital — Length of stay in lb: 49 days

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 (If outside, give location): 23 Warner Plaza — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First JOSEPH Middle Lapsley Last KENNEDY

4. DATE OF DEATH: Month June Day 10, Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 7-14-95
9. AGE (In years last birthday): 63 — 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): Taxi-cab driver
10b. KIND OF BUSINESS OR INDUSTRY: Yellow Cab Co.
11. BIRTHPLACE (City and state or country): Marshall, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Joseph L. Kennedy
13b. MOTHER'S MAIDEN NAME: Anna Walden
14. NAME OF HUSBAND OR WIFE: Anna Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO.: 496 16 3481
17. INFORMANT: VA Hospital records — 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): Neoplasm liver and mediastinal glands, type unknown — INTERVAL BETWEEN ONSET AND DEATH: Approx 5 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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): Tuberculosis, pulmonary, chronic, far advanced, inactive 1992 A
19. WAS AUTOPSY PERFORMED? YES [XX] NO [ ]

MEDICAL CERTIFICATION

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. VA attended the deceased from April 22, 1959, to June 10, 1959 xxxxxxxxxxxxxxxx
Death occurred at 7:35 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): F. J. MANTELL, Acting Pathologist
22b. ADDRESS: VACC, Ex. Spgs Div., Ex. Spgs Div.
22c. DATE SIGNED: 6-11-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6-15-59
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Ft Leavenworth, Kansas

24. FUNERAL DIRECTOR: Prichard Funeral Home, ADDRESS: Excelsior Springs Mo.
25. DATE RECD. BY LOCAL REG.: 6-15-1959
26. REGISTRAR'S SIGNATURE: Caroline Hutchings

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

AUG 11 1960

REC
JUL 2
CLAY
HEALTH

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 Ralph Van Landingham

Licensed Embalmer No. 4009

P. O. Address Colorado Springs, Colo.

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.