

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023074

FILED JUL 3 1959

STATE FILE NUMBER  
Registration No. 5687

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Richmond Heights 4505 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint John's		Length of stay in lb. 5 days	d. STREET ADDRESS (If outside, give location) 19 Thorndell Drive Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Francis L. Kennedy M.D.			4. DATE OF DEATH Month Day Year June 13 1959
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ear, Nose & Throat		10b. KIND OF BUSINESS OR INDUSTRY Doctor	9. AGE (In years last birthday) 55 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
11. BIRTHPLACE (City and state or country) Tempelton, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Patrick Kennedy		13b. MOTHER'S MAIDEN NAME Ella Carroll	14. NAME OF HUSBAND OR WIFE Mrs. Nancy Kennedy (Wife)
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.	17. INFORMANT Address Mrs. Nancy Kennedy 19 Thorndell Drive R.H.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			<i>330x</i>
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 checked="" type="checkbox"/> NO <input 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 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
21. I attended the deceased from <i>March 1954</i> to <i>June 1959</i> and last saw <sup>him</sup> <i>June 13, 1959</i> Death occurred at <i>2:00 pm</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Martin W. Davis, M.D.</i>		22b. ADDRESS <i>539 N. Grand Ave.</i>	22c. DATE SIGNED <i>6/15/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>June 16, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Saint Louis Missouri</i>
24. FUNERAL DIRECTOR ADDRESS <i>Arthur J. Donnelly 3840 Lindell Blvd.</i>		25. DATE RECD. BY LOCAL REG. <i>JUN 15 '59</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Pearl Smith, M.D.</i>

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 James H. Williams

Licensed Embalmer No. 3565  
P. O. Address 3940 Leake

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.