

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037752

FILED VS. NOV. 3 1959

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STATE FILE NUMBER

INDEXED

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>			Length of stay in 1b		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>Bernard Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4385 Maryland Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>SCRUGGS</b> Last <b>KENNARD</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>24</b> , Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/10/1884</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpet Company</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Samuel M. Kennard</b>			13b. MOTHER'S MAIDEN NAME <b>Annie Maud</b>		14. NAME OF HUSBAND OR WIFE <b>Louise N. Kennard</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W.I none</b>		17. INFORMANT <b>Mrs. W.W. Boyd 122 Bemiston, Clayton Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency</b>						<b>1/2 day</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b>						<b>6 years</b>	
DUE TO (c) <b>Generalized Arteriosclerosis</b>						<b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 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>15 Sept 1953</b> to <b>24 Oct 1959</b> and last saw her/him alive on <b>24 Oct 1959</b> Death occurred at <b>Twelve noon</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>John W. Seddon M.D.</b>			22b. ADDRESS <b>4500 West Pine Blvd St. Louis 8, Mo</b>		22c. DATE SIGNED <b>25 Oct '59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>Oct. 26, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri.</b>		
24. FUNERAL DIRECTOR <b>C.R. Lupton and Sons 7233 Delmar Blv'd.</b>			25. DATE RECD. BY LOCAL REG. <b>OCT 26 1959</b>		26. REGISTRAR'S SIGNATURE <b>Loard Smith M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.