

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS NOV 12 1959**

**59-037754**

**210025**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b> <b>INCARNATE WORD HOSPITAL</b>		Length of stay in 1b <b>18 DAYS</b>	c. CITY OR TOWN <b>ST. LOUIS</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>INCARNATE WORD HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4437 WALLACE</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>WALTER</b>	First	Middle <b>M.</b>	Last <b>KENNER</b>	4. DATE OF DEATH <b>10-30-1959</b>	Month	Day	Year
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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>8-8-1901</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRESS MAN</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>PRINTING</b>	11. BIRTHPLACE (City and state or country) <b>HERCULANUM, MO</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
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13a. FATHER'S NAME <b>CHARLES KENNER</b>	13b. MOTHER'S MAIDEN NAME <b>ELIZABETH HAHIV</b>	14. NAME OF HUSBAND OR WIFE <b>ELIZABETH KENNER</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES 1918</b>	16. SOCIAL SECURITY NO. <b>489-05-6284</b>	17. INFORMANT <b>ELIZABETH KENNER 4437 WALLACE</b>	Address
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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>Bronchiogenic Carcinoma Left</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>162.1</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Old Cardio-Vascular Renal disease</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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from **9-14-59** to **10-30-59** and last saw him alive on **10-30-59**  
 Death occurred at **8<sup>00</sup>** P<sup>m</sup> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Andrew B. Kenner, M.D.</b>	(Degree or title)	22b. ADDRESS <b>4632 So Grand</b>	22c. DATE SIGNED <b>10-31-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>11-2-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CHURCH YARD</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, MO</b>
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24. FUNERAL DIRECTOR <b>HOWARD H. MICHEL</b>	ADDRESS <b>5930 SOUTHWEST</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 2 1959</b>	26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mjs*

**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 W E Morris

Licensed Embalmer No. 336  
P. O. Address St Louis

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.