

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007420

FILED VS MAR 7 1960

Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 50

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Nodaway</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Nodaway</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maryville</b>		Length of stay in 1b <b>19 days</b>		c. CITY OR TOWN <b>Parnell</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>St. Francis Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>none</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLOSSIE</b> Middle <b>MAY</b> Last <b>KENNEDY</b>				4. DATE OF DEATH Month <b>3</b> Day <b>2</b> Year <b>60</b>			
5. SEX <b>Female</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>4/8/83</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (City and state or country) <b>Williamsburg, Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>William Brown</b>			13b. MOTHER'S MAIDEN NAME <b>Sarah Haines</b>		14. NAME OF HUSBAND OR WIFE <b>Harlen 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>none</b>		17. INFORMANT Address <b>Harlen Kennedy, Parnell, Mo.</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>Cardio-vascular renal disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>+ Renal Failure Chronic</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>&gt; 1 yr -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ s.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>8/11/59</b> to <b>5/2/60</b> and last saw her <sup>per husband</sup> live on <b>3/1/60</b> . Death occurred at <b>1:00</b> A. M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>M. D.</b>				22b. ADDRESS <b>Maryville, Missouri</b>		22c. DATE SIGNED <b>3/4/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>3/4/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bolckow</b>		23d. LOCATION (City, town, or county) <b>Bolckow, Missouri</b>		
24. FUNERAL DIRECTOR <b>Price Funeral Home, Maryville, Mo.</b>				ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3-4-60</b>	26. REGISTRAR'S SIGNATURE <b>Bess Holt</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed John W. Price

Licensed Embalmer No. 4281

P. O. Address Maryville

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.