

RI· DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028512

FILED VS. AUG 8 1960

318

Primary Registration District No. 1003

Registrar's No. 7617

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS,		Length of stay in 1b		c. CITY OR TOWN ST LOUIS,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DEPAUL HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2516 a SALISBURY ST.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BARBARA ANN KENNEDY				4. DATE OF DEATH Month Day Year JULY 31, 1960				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH SEPT 23, 1949	9. AGE (last birthday) 10	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) AT HOME - SCHOOL			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME WILLIAM KENNEDY			13b. MOTHER'S MAIDEN NAME HELEN ALEWEL			14. NAME OF HUSBAND OR 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. NONE		17. INFORMANT WILLIAM KENNEDY 2516 a SALISBURY ST.				
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>Pneumonia</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Pulmonary Fibrosis</i> DUE TO (c) <i>Cystic Fibrosis of Pancreas</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i> <i>2 yrs</i> <i>9 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>5873</i>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N. <input type="checkbox"/> Unknown		
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 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 <i>birth</i> to <i>July 31 60</i> and last saw her <i>live on July 31-60</i> Death occurred at <i>2 30 pm</i> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Lee Smith M.D.</i>				22b. ADDRESS <i>1553 M = Loran</i>		22c. DATE SIGNED <i>Aug 1-60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE <i>8/3/60</i>	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) ST LOUIS MISSOURI			(State)
24. FUNERAL DIRECTOR STROOT - CARROLL 4600 NATURAL BRIDGE				25. DATE RECD. BY LOCAL REG. AUG 1 1960		26. REGISTRAR'S SIGNATURE <i>Lee Smith M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Agreed  
for 599-12  
1453 m. 07/09/01  
Kathleen 3 PM*

**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 M. W. Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.