

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 27 1960

-60-038433

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5114

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Camden</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>1 wk.</b>	c. CITY OR TOWN <b>Camdenton</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>1305 Prospect</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rural Route</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>HALLEY</b> Last <b>KENNEDY</b>			4. DATE OF DEATH Month <b>10</b> Day <b>7</b> Year <b>60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-29-82</b>	9. AGE (last birthday) <b>78</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>Interior Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Remodeling</b>		11. BIRTHPLACE (City and state or country) <b>La Cygne, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Alva J. Kennedy</b>		13b. MOTHER'S MAIDEN NAME <b>Agnes Jane Stewart</b>		14. NAME OF HUSBAND OR WIFE <b>Kathryn 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>487-12-5631A</b>		17. INFORMANT <b>Mr. Robert L. Kennedy; 7201 Highland</b> Address <b>K.C., 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>Cerebral Thrombosis</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Arteriosclerotic Heart Disease</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 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 _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <b>E. W. Hooley, Jr., M.D., M.P.H., M.P.H.</b>		22b. ADDRESS <b>6627 Pembroke Ave</b>		22c. DATE SIGNED <b>10-10-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-11-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Tabor Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Odessa, Lafayette Co., Mo.</b>	
24. FUNERAL DIRECTOR <b>WEILERT FUNERAL HOMES(S) K.C., MO.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-11-60</b>	26. REGISTRAR'S SIGNATURE <b>H. L. Sawyer</b>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

X

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed B. E. Weid

Licensed Embalmer No. 707

P. O. Address L.C.

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.

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EMBALMER

STATE BOARD