

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001462

MISSOURI DIVISION OF PUBLIC HEALTH AND WELFARE

WRITE
IT UP

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 91

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa b. COUNTY Allegheny	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 1 day	c. CITY OR TOWN New Kingston Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Northeast Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1331 Victoria Ave Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOHN Middle DUER Last KENNEDY			4. DATE OF DEATH Month January Day 6 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/27/1877	9. AGE (last birthday) 83	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) Retired		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith	11. BIRTHPLACE (City and state or country) Murraysville Pa	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME John Elliott Kennedy		13b. MOTHER'S MAIDEN NAME Belle Duer		14. NAME OF HUSBAND OR WIFE Eva Kennedy (Dec)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Curtis Kennedy 4636 E 8th K C Mo		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest** INTERVAL BETWEEN ONSET AND DEATH **28 hrs**

DUE TO (b) **Difuse arteriosclerosis**

DUE TO (c) **Iliac embolis**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Carcinoma of bladder Matastisis to liver

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No 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 **Jan 5 1961** to **Jan 6 1961** and last saw her/him alive on **Jan 6 1961**
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) <i>W. Thompson</i>	22b. ADDRESS 62150 1st St K C Mo	22c. DATE SIGNED 1-6-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/7/1961	23c. NAME OF CEMETERY OR CREMATORY New Kingston Pa
23d. LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home Kansas City Mo	

25. DATE RECD. BY LOCAL REG. 1-7-61	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>
---	---

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

W. Thompson MEDICAL CERTIFICATION

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 Thomas A. Smith

Licensed Embalmer No. 4934

P. O. Address A.C. Mo.

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.