

318

1003

10218

=61-038816

STATE FILE NUMBER

AMENDED

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

1. PLACE OF DEATH a. COUNTY <u>                    </u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>                    </u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>1 yr 8mo</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Masonic Home of Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4214 Westminister</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>                    </u> Last <u>Kennedy</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1961</u>			
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/89</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>                    </u> Days <u>                    </u>	IF UNDER 24 HR Hours <u>                    </u> Min. <u>                    </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>                    </u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
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13a. FATHER'S NAME <u>Frank S. Bean</u>	13b. MOTHER'S MAIDEN NAME <u>Frida Spraul</u>	14. NAME OF HUSBAND OR WIFE <u>Joseph Kennedy</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>                    </u>	17. INFORMANT <u>Masonic Home of Mo.</u> Address <u>                    </u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		<u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized arteriosclerosis</u>	<u>unk</u>
	DUE TO (c) <u>4201</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>                    </u>	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
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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.) <u>                    </u>
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20c. TIME OF INJURY Hour <u>                    </u> a.m. <u>                    </u> p.m. <u>                    </u> Month, Day, Year <u>                    </u>	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.) <u>                    </u>	20f. CITY, TOWN, OR LOCATION <u>                    </u>	COUNTY <u>                    </u> STATE <u>                    </u>
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21. I attended the deceased from <u>3/5/60</u> to <u>10/31/61</u> and last saw <u>her</u> alive on <u>10/31/61</u> Death occurred at <u>10:47 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Harold E. Walters MD</u>	22b. ADDRESS <u>3720 Washington St. Louis</u>	22c. DATE SIGNED <u>11-2-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-3-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kinder Cemetery</u>	23d. LOCATION (City, town, or county) <u>Cuba, Mo.</u>
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24. FUNERAL DIRECTOR <u>Hoener Funeral Home, Cuba, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 2 1961</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 \_\_\_\_\_

*Harney Kahle*

Licensed Embalmer No. 4596

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.