

**SOURI DIVISION OF PUBLIC HEALTH AND WELFARE - STANDARD CERTIFICATE OF DEATH**

11303 - 61-042584  
 STATE FILE NUMBER

318  
 Registration District No.

1003  
 Primary Registration District No.

11303  
 Registrar's No.

DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**FILED DEC 12 1961**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>				Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4969 Pershing Place</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4969 Pershing Place</b>	
3. NAME OF DECEASED (Type or print)		First <b>Samuel</b>		Middle <b>M.</b>		Last <b>Kennard Jr.</b>	
4. DATE OF DEATH		Month <b>December</b>		Day <b>3</b>		Year <b>1961</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>2/25/1883</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpet Co.</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Samuel M. Kennard</b>			13b. MOTHER'S MAIDEN NAME <b>Annie Maude</b>			14. NAME OF HUSBAND OR WIFE <b>Ethel</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>Unknown</b>		17. INFORMANT Address <b>Samuel M. Kennard III, 4970 Pershing Place</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>MYOCARDIAL INFARCTION due to POSTERIOR CORONARY OCCLUSION</b>						<b>6 DAYS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <b>ARTERIOSCLEROSIS; GENERALIZED</b>	
						<b>15 YEARS</b>	
DUE TO (c) <b>ARTERIO SCLEROTIC HEART DISEASE</b>						<b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>						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 <b>9 AUGUST 1939</b> , to <b>3 DEC '61</b> and last saw <sup>him</sup> alive on <b>2 DECEMBER 1961</b> Death occurred at <b>5 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>John W. Seddon MD</b> (Degree or title)				22b. ADDRESS <b>4500 West Pine Blvd St. Louis Mo</b>		22c. DATE SIGNED <b>4 Dec '61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-4-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>DEC 4 1961</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>	

**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 W W Wilkinson

Licensed Embalmer No. 3575

P. O. Address W Loring Mc

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.