

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020604

DEPARTMENT OF PUBLIC HEALTH AND WELFARE **318**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**5146** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED MAY 31 1962**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b <i>4 Days</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Jefferson</i>		c. CITY OR TOWN <i>Cedar Hill</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Deaconess Hospital</i>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>Route 1 Box 246</i>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>JAMES GODFREY KENNINGTON</i>						4. DATE OF DEATH Month Day Year <i>May 20 1962</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>3-25-1895</i>		9. AGE (last birthday) <i>67</i>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't.</i>		11. BIRTHPLACE (City and state or country) <i>Lebanon, Illinois</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>					
13a. FATHER'S NAME <i>John M. Kennington</i>				13b. MOTHER'S MAIDEN NAME <i>Ema L. Breuning</i>				14. NAME OF HUSBAND OR WIFE <i>Nona</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Yes W.W. 1</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>M. Mildred Kennington Cedar Hill Mo</i> Address							
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) <i>Cerebral Hemorrhage</i>												<i>3 days</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic CVSDisease</i>												<i>7 years</i>	
DUE TO (c) <i>422.1</i>													
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 <i>1948</i> to <i>5/20/62</i> and last saw him alive on <i>5/20/62</i> Death occurred at <i>10 P</i> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Earl L Brand M.D.</i>						22b. ADDRESS <i>Webster Groves Mo</i>			22c. DATE SIGNED <i>5/21/62</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>5-23-1962</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oakwood Cemetery</i>		23d. LOCATION (City, town, or county) <i>Alton, Illinois</i>		(State)					
24. FULL NAME AND ADDRESS <i>MITTELBERG - GERBER COLONIAL CHAPEL</i>						25. DATE RECD. BY LOCAL REG. <b>MAY 21 1962</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>					

USE BLACK INK OR TYPEWRITER RIBBON

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**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 Harvey Kahl

Licensed Embalmer No. 4596

P. O. Address St. Louis, 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.