

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-028832  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7513**

VS 300  
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

4000-3A

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DOCUMENT

MEDICAL CERTIFICATION

<p><b>FILED AUG 6 1962</b></p>		<p>1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST LOUIS</b></p>	
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS</b></p>		<p>Length of stay in 1b <b>2 DAY</b></p>		<p>c. CITY OR TOWN <b>AFETON</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST ANTHONY HOSPITAL</b></p>			<p>Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p>		<p>d. STREET ADDRESS (If outside, give location) <b>9422 ARNO DR.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA LENA KENNEBECK</b></p>			<p>4. DATE OF DEATH Month Day Year <b>JULY - 30 - 1962</b></p>		
<p>5. SEX <b>FEMALE</b></p>	<p>6. COLOR OR RACE <b>WHITE</b></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>9-30-1889</b></p>	<p>9. AGE (last birthday) <b>72</b></p>	<p>IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <b>10 0</b></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b></p>		<p>11. BIRTHPLACE (City and state or country) <b>ST LOUIS Mo</b></p>	<p>12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b></p>
<p>13a. FATHER'S NAME <b>ERNEST REICHEL</b></p>		<p>13b. MOTHER'S MAIDEN NAME <b>SALONE BRAUN</b></p>		<p>14. NAME OF HUSBAND OR WIFE <b>BERNARD KENNEBECK</b></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>—</b></p>		<p>16. SOCIAL SECURITY NO. <b>—</b></p>	<p>17. INFORMANT Address <b>HELEN KNOLL 9422 ARNO DR ST LOUIS 28 MO</b></p>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p>					<p>INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b></p>
<p>IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b></p>					<p>DUE TO (b) <b>arteriosclerotic Heart Disease</b></p>
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>420.0</b></p>					<p>DUE TO (c) <b>—</b></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>Diabetes mellitus - Cholelithiasis</b></p>				<p>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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>20f. CITY, TOWN, OR LOCATION</p>	<p>COUNTY STATE</p>
<p>21. I attended the deceased from <b>6/1/62</b> to <b>7/30/62</b> and last saw her alive on <b>7/30/62</b> Death occurred at <b>1130 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>					
<p>22a. SIGNATURE (Degree or title) <b>Harold A. Franklin, M.D.</b></p>			<p>22b. ADDRESS <b>16 Hampton Valley Pkwy</b></p>		<p>22c. DATE SIGNED <b>7/1/62</b></p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b></p>	<p>23b. DATE <b>AUG-1-1962</b></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVE Cem</b></p>		<p>23d. LOCATION (City, town, or county) <b>Lemay Mo</b></p>	<p>(State)</p>
<p>24. FUNERAL DIRECTOR ADDRESS <b>FEY FUNERAL HOME MEHLVILLE Mo</b></p>			<p>25. DATE RECD. BY LOCAL REG. <b>JUL 31 1962</b></p>	<p>26. REGISTRAR'S SIGNATURE <b>Loed Smith, M.D.</b></p>	

**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

*Mustaw W. Dietrich*

Licensed Embalmer No. 4329

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.