

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4332**
Registrar's No. **0166**

REG. DIST. NO. **307** PRIMARY REG. DIST. NO. **500**

PLACE OF DEATH **MANCHESTER NURSING HOME** COUNTY **ST. LOUIS**
USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE **WISCONSIN** b. COUNTY **DANE**

c. CITY (If outside corporate limits, write RURAL and give township) **MADISON** 8480
d. FULL NAME OF HOSPITAL OR INSTITUTION **MANCHESTER NURSING HOME** e. STREET ADDRESS (If rural, give location) **418 WASHBURN PL.**

3. NAME OF DECEASED a. (First) **SELENA** b. (Middle) **MC** c. (Last) **KENNA** 4. DATE OF DEATH (Month) (Day) (Year) **JAN. 17, 1953**

5. SEX **FEMALE** 6. COLOR OR RACE **WHITE** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED **WIDOWED** 8. DATE OF BIRTH **JAN. 9 1876** 9. AGE (In years last birthday) **77** IF UNDER 1 YEAR Months **8** IF UNDER 1 HRS. Days **8** Hours **8** Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOUSE WIFE** 10b. KIND OF BUSINESS OR INDUSTRY **DOMESTIC** 11. BIRTHPLACE (State or foreign country) **BLUEMOUNDS WISCONSIN** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **OLLIE THOURHAUG** 13b. MOTHER'S MAIDEN NAME **EMMA ERICKSON** 14. NAME OF HUSBAND OR WIFE **JOHN G. MCKENNA**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **NONE** 17. INFORMANT'S SIGNATURE OR NAME **MRS. R.P. BRESLO** ADDRESS **525 PURDUE**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) **Bronchopneumonia**

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Bronchopneumonia** INTERVAL BETWEEN ONSET AND DEATH **4 days**

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) **Cerebral arteriosclerosis**

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. **Cerebral arteriosclerosis**

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION **491X** 20. AUTOPSY? YES NO

21a. ACCIDENT (Specify) **(Specify)** 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan 16, 1953**, to **Jan 17, 1953**, that I last saw the deceased alive on **Jan 16, 1953**, and that death occurred at **3:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE **James S. January Jr** (Degree or title) **MD** 23b. ADDRESS **35 North Central, Clayton, Mo.** 23c. DATE SIGNED **Jan 18, 1953**

24a. BURIAL, CREMATION, REMOVAL (Specify) **REMOVAL** 24b. DATE **JAN. 18, 1953** 24c. NAME OF CEMETERY OR CREMATORY **CALVARY CEM.** 24d. LOCATION (City, town, or county) (State) **MADISON WISCONSIN**

DATE REC'D BY LOCAL REG. **1-18-53** REGISTRAR'S SIGNATURE **Hackett R. Donohue M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE **G. H. Booklage** ADDRESS **6536 Clayton St.**

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

8

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
Student Embalmer

Signed *Fred J. Garner*

Licensed Embalmer No. *4788*

P. O. Address *St. Louis Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.