MAY 27 1927

1409 E. Delmar

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

11410

1. PLACE OF DEATH
County Greene — Registration District No. 310
Township — Primary Registration District No. 2001
City Springfield (No. 229 W. Lynn St. Ward)

File No.
Registered No. 209

2. FULL NAME Daniel Warren Kerr
(a) Residence. No. 229 W. Lynn St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Matilda Z. Kerr

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 13-1856

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
70	10	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa.

PARENTS
10. NAME OF FATHER Daniel Kerr
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER — Rishel
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Mrs. Matilda Z. Kerr
(Address) Springfield, Mo.

15. April 3, 1927 O. C. Horst M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 2nd 1927

17. I HEREBY CERTIFY, That I attended deceased from Mch 18, 1927, to Apr 2, 1927, that I last saw him alive on Apr 2, 1927, and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of the Rectum

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 45

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) I. L. James, M.D.
Apr 2, 1927 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Cleveland Ohio
DATE OF BURIAL: 4/ 1927

20. UNDERTAKER: J. W. Klingner & Co 424 E. Coml Springfield, Mo
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACT. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAR 6 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2001 — Registered No. 209
City Springfield (No. ..... St. ..... Ward)

2. FULL NAME Daniel Warren Kerr
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unknown & Rishel
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 4/3, 1927 O C Horst Mbr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 2 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

SUPPLEMENTAL

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

...ver, item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... very important.

S-11410