

AY 28 1928

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

Do not use this space.

12641

1. PLACE OF DEATH

County Clay
Township Fishing River
City Excelsior Springs, Mo.

Registration District No. 198
Primary Registration District No. 3011

File No. _____
Registered No. 40
St. _____ Ward _____

2. FULL NAME Hewitt L. Karr

(a) Residence No. U.S. Veterans' Hospital #99, Ward. Wellman, Iowa.
(Usual place of abode) Excelsior Springs, Mo. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 8 mos. 3 ds. 16 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 Delphi Karr

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 18, 1876

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
51 5-1 11 24

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Wellman, Iowa
(STATE OR COUNTRY) Iowa.

10. NAME OF FATHER William C. Karr.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER Jennie Jewitt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Iowa.

14. INFORMANT deceased.
(Address) _____

15. FILED 4/30/28 Y.A.O. Craven
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12, 19 28

I HEREBY CERTIFY That I attended deceased from Dec. 27, 19 27, to April 12, 19 28 that I last saw him alive on April 12, 19 28 and that death occurred, on the date stated above, at 6:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardio renal disease

CONTRIBUTORY Chronic interstitial nephritis.
(SECONDARY) Unknown.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. Unknown.

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

20. WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS. Clinical symptoms & laboratory findings.

(Signed) _____ M. D.
, 19 (Address) A.R. WARNER

*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

Wellman, Iowa. 4/15/28 19

20. UNDERTAKER ADDRESS
Herbert Hope Ex. Spgs. Mo.

A-25.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

