V 22 1928

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

Do not use this space.

X 31082

1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No.

Township Mason — Primary Registration District No. 3029 — Registered No. 274

City Hannibal Mo (No. 1605 D Street St. Ward)

2. FULL NAME Catherine L. Kerns

(a) Residence. No. 1605 D St 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-28-27

7. AGE: Years 1 — Months 3 — Days 1 — 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) Hannibal
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Oval Kerns
11. BIRTHPLACE OF FATHER (CITY OR TOWN) —
(STATE OR COUNTRY) Iowa
12. MAIDEN NAME OF MOTHER Alma Stephens
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Hannibal
(STATE OR COUNTRY) Mo

14. INFORMANT Oval Kerns
(Address) 1605 D St. Hannibal Mo

15. FILED 10/10, 1928 C. E. Sliode
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-29-1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 25, 1928, to Sept 29, 1928 that I last saw her alive on Sept 29, 1928, and that death occurred, on the date stated above, at 1-30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cholrea Infantum
1190
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Bad Drinking water
(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? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) C E Salyer, M. D
, 19 (Address) Hannibal 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: Hope Cemetery — DATE OF BURIAL: 10-1-1928

20. UNDERTAKER: James O'Donnell — ADDRESS: Hannibal Mo.

N. B.—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.