

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

Do not use this space.

7913

1. PLACE OF DEATH **ST. LOUIS.**
 County **ST. LOUIS**
 Township **CARONDELLET**
 City **St. Louis** (No. **W. H. Rose**)

Registration District No. **1123**
 Primary Registration District No. **6248** **F**

File No. _____
 Registered No. **73**
 St. _____ Ward _____

2. FULL NAME **Kennett Kern**
 (a) Residence No. **8269 Albin** St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF **Jan 27, 1875**
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan 29 - 1875**
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **54 0 15**
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Farmer**
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER **Ben Kern**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Indiana**
 12. MAIDEN NAME OF MOTHER **Anna**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Mo**

14. INFORMANT **Mrs. May Diltow**
 (Address) **8269 Albin**

15. FILED **Feb 14 1929** **L. C. Obrock, M.D.**
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2-14-29** 19
 17. I HEREBY CERTIFY, That I attended deceased from **2-6-29**, 19, to **2-14-29**, 19, that I last saw h. **alive** on **2-14-29**, 19, and that death occurred, on the date stated above, at **5:00 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CHRONIC PULMONARY TUBERCULOSIS
23A (duration) yrs. mos. da. _____
 CONTRIBUTORY (SECONDARY) **31** (duration) yrs. mos. da. _____

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____
 WAS THERE AN AUTOPSY? **no**
 WHAT TEST CONFIRMED DIAGNOSIS? **Virgino**
 (Signed) **Louis C. Borchman, M.D.**
 , 19 (Address) **9101 S. Broadway**

*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 **Lutesville Mo.** DATE OF BURIAL **Feb. 16 1929**

20. UNDERTAKER **Reety Bros, Und. Cos.** ADDRESS **3029 Lafayette**

J. C. Borchman, M.D.

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. MAR 27 1929

1863

Putnamville, Mo
Sept 16