OCT 28 1930

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

Do not use this space.

29491

1. PLACE OF DEATH
County Dallas
Township Grant
City Louisburg (No. ..... St. ..... Ward)

Registration District No. 747
Primary Registration District No. 3335

File No. 12
Registered No.

2. FULL NAME John Virgil Karr
(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: 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 Della Karr

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June-16-1892

7. AGE: Years 38, Months 4, Days 10. If LESS than 1 day, ... hrs. or ..... min.

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) Dallas Co.
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Ed Karr
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dallas Co
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Emma Southard
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dallas Co
(STATE OR COUNTRY) Missouri

14. INFORMANT Della Karr
(Address) Louisburg Mo

15. FILED 10/9 1930 W E Gammon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept-26-1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Sept 26, 1930 that I last saw him alive on Sept 26, 1930, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular Heart Disease
92A
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) None
(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) W E Gammon, M. D.
, 19 (Address) Louisburg 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: New Hope
DATE OF BURIAL: Sept 28 1930

20. UNDERTAKER: L. B. Jones
ADDRESS: Buffalo 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.

...ITH UNLEADING INK---THIS IS A PERMANENT RECORD