

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH: 1013

(a) County: St. Louis MO 2

(b) City or town: St. Louis MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3052 Vermont
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED: 1

(a) State: Mo (b) County: _____

(c) City or town: St. Louis 12
(If outside city or town limits, write "RURAL")

(d) Street No.: 3052 Vermont
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME: MYRTLE KERR 60?

3. (b) If veteran, name war: No

3. (c) Social Security No. _____

4. Sex: Female 5. Color or race: White

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Apr 28, 1902
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26
year 1939 hour 3 P.M. minute 30 P.M.

21. I hereby certify that I attended the deceased from April 2nd
_____, 1937, to Nov 26 _____, 1939;
that I last saw her alive on Nov 26 _____, 1939;
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>37</u>	<u>6</u>	<u>28</u>	hr. _____ min. _____

Immediate cause of death: Carcinoma Duration 2 yrs

Due to: Carcinoma

9. Birthplace: Colorado
(City, town, or county) (State or foreign country)

10. Usual occupation: Office Work

11. Industry or business: Unemployed 1

MOTHER FATHER {

12. Name: Patrick Kerr 5

13. Birthplace: Ireland 5
(City, town, or county) (State or foreign country)

14. Maiden name: Ezzabeth Fullin

15. Birthplace: Ireland
(City, town, or county) (State or foreign country)

Due to: Primary site left kidney

Other conditions: 53
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of intestines and left kidney

Of autopsy: no

PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature: John Doonan

(b) Address: 4584 Locust

17. (a) Burial (b) Date thereof: _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Cemetery

18. (a) Signature of funeral director: J. J. [unclear]

(b) NOV 28 1939

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature: C. J. [unclear] (M. D. or other) _____

Address: 1816A n Grand Date signed: Nov 28

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
1 X1931

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *P. W. F. ...*

Licensed Embalmer No. *1591*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.