

FILED MAR 19 1940

State File No. \_\_\_\_\_

Registration District No. 290

Primary Registration District No. 5408 4174

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Dunklin  
 (b) City or town Smith  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_

(If not in hospital or institution, write street number or location) 20  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community Life  
 years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME Gerald Wayne Karnes

3. (b) If veteran, name war L 3. (c) Social Security No. L

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
 alive \_\_\_\_\_ years

7. Birth date of deceased Nov 19 - 1934  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
5 3 14 hr. \_\_\_\_\_ min.

9. Birthplace Boonville Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Emily Karnes

13. Birthplace Boonville Missouri  
 (City, town, or county) (State or foreign country)

14. Maiden name Emily Collins

15. Birthplace Smith Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant Dr. Karnes

(b) Address Boonville Mo

17. (a) Burial (b) Date thereof 3-4-1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McDrew

18. (a) Signature of funeral director M. D. Daniel

(b) Address Boonville Mo  
 19. (a) Mar 6 1940 (b) D. D. Daniel  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Dunklin  
 (c) City or town Smith Mo  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? ✓ \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 3  
 year 1940 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3-2-40  
 \_\_\_\_\_, 19\_\_\_\_, to 3-3-40, 19\_\_\_\_;  
 that I last saw him alive on 3-2-40, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Diphtheria

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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?  
 \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature A. T. Murphy (M. D. or other)  
 Address Smith Mo Date signed 3-5-40

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. \_\_\_\_\_

District File Number 340-79

Date Filed 3/14/40

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**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 \_\_\_\_\_

*not embalmed*

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.**