

APR 23 1940

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

Do not use this space.

12719

1. PLACE OF DEATH  
 County Hosers Vernon Registration District No. 879  
 Township Herry. Primary Registration District No. 6167  
 City same. Mo. (No. 2) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Samantha Ellen Kerns.  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED  
 (or) WIFE OF Jerry Kerns.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 18 1853.

7. AGE YEARS 86 MONTHS 11 DAYS 4 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife.  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio.

FATHER  
 13. NAME Andrew Bogan.  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana.

MOTHER  
 15. MAIDEN NAME Amanda Jane Thompson.  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana.

17. INFORMANT (ADDRESS) Walter W. Kerns. Home  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Hume Cemetary. DATE March 26 1940  
 19. UNDERTAKER (ADDRESS) R. W. McConnell & Son. Hume. Mo.  
 20. FILED 4-5- 1940 Minnie B. Denton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 22 1940

22. I HEREBY CERTIFY, That I attended deceased from June 1st 1940 to Mar 22 1940  
 Last saw her alive on Mar 21 1940 Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
Heptostasis Pneumonia 20/40  
Coronary Sclerosis 1939

Other contributory causes of importance:  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis clinical Was there an autopsy no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) Wm. F. Allen M. D.  
 (Address) Hume

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS who state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

94B

United States Department of Health

CONFIDENTIAL

RECEIVED  
District Health Officer No. 7,  
District Health 4-40-547  
District File Number 4-8-42  
Date Filed

Department of Health  
Washington, D.C.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12719

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 879

Primary Registration District No. 6167

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

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

1. PLACE OF DEATH:

(a) County Wagon  
(b) City or town Henry  
(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)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Samantha Ellen Kern

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 86 Months 11 Days 4 If less than one day, hr. min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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.

20. DATE OF DEATH Month Mar day 22 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Hypostatic pneumonia, lobes  
Due to \_\_\_\_\_

Other conditions Coronary sclerosis  
(Include pregnancy within 3 months of death)

Major findings: Of operations 105

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 Wm H. Allen (M. D. or other) \_\_\_\_\_

Address Home, Mo Date signed \_\_\_\_\_

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-12719 - 1940