

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 213

Primary Registration District No. 2014

Registrar's No. 81

1. PLACE OF DEATH:

(a) County Cole  
(b) City or town Jefferson City.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Marys Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole  
(c) City or town Lohman, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Adam John Kerl 640

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased June 24, 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 9 9 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Decorator

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

MOTHER FATHER { 12. Name John Kerl  
13. Birthplace UNKNOWN 9  
(City, town, or county) (State or foreign country)  
14. Maiden name UNKNOWN  
15. Birthplace 9  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Minnie Kerl  
(b) Address Lohman, Mo.

17. (a) Removal (b) Date thereof April 5, 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Springwood Cem.

18. (a) Signature of funeral director J. H. Stephens  
(b) Address Russellville, Mo.

19. (a) 4-5-40 (b) Subscribed  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd,  
year 1940 hour 6-0 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 3/7/40 to 4/3/40,  
that I last saw him alive on 4/2/40, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage of sigmoid  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to 46  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Cerebral hemorrhage of sigmoid.  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

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 Subscribed (M. D. or other) M.D.  
Address Jeff City Mo. Date signed 4/5/40

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.....

*Ray O. Stephens*  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*Ray O. Stephens*

Licensed Embalmer No. *4022*

P. O. Address

*Russellville*

**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.**