

U. S. No. 2
M-11-10-39
Rev. 5-17-39
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16747

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

ED JUN 15 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4225

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Baptist 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 _____
(c) City or town Sullivan NR
(If outside city or town limit, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Christina Kerr 600

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Female 6. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased. Sept. 5 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 8 5 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Boyer

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

14. Maiden name Mary Ann Stewart

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

16. (a) Informant Rose Boyer

(b) Address Sullivan, Mo.

17. (a) Removal (b) Date thereof 5-11-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anaconda, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) MAY 11 1940 (b) _____
(Date received local registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day May
year 1940 hour 10 minute _____ M.

21. I hereby certify that I attended the deceased from May 10, 1940, to May 10, 1940,
that I last saw her alive on May 10, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of ovary

Due to _____

Due to _____

Other conditions Cerebral Hemorrhage
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of ovary
Of operations _____
Of autopsy Cerebral Hemorrhage

Duration

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 Albert H. Hoppe (M. D. or other)
Address 462 N. Taylor Date signed _____

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

MOTHER FATHER

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 J. S. Sullivan

Licensed Embalmer No. 1122

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.