

Registration District No. 293

Primary Registration District No. 4177

Registrar's No.

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Pacific  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN ALLEN KERN

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

4. Sex Male 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 1 years

7. Birth date of deceased May 9 - 1917 (Month) (Day) (Year)

8. AGE: Years 23 Months 5 Days 11 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business 0

MOTHER FATHER { 12. Name John Kern  
13. Birthplace St. Louis Mo (City, town, or county) (State or foreign country)  
14. Maiden name Helen Mahan  
15. Birthplace St. Louis Mo (City, town, or county) (State or foreign country)

16. (a) Informant John Kern

(b) Address Pacific Mo

17. (a) Burial (b) Date thereof 10/22/40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pacific Mo

18. (a) Signature of funeral director Geo. L. Thisher

(b) Address Pacific Mo 266

19. (a) Oct. 21, 40 (b) Mary O. Gross (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin  
(c) City or town Pacific 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 Oct day 20 year 1940 hour 1 minute 30 A.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 Acute Endocarditis

Due to not known

Due to at home

Other conditions (Include pregnancy within 3 months of death)

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

Of autopsy none

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

(a) Accident, suicide, or homicide (specify) not

(b) Date of occurrence Oct 20 1940

(c) Where did injury occur? Rural Pacific Mo (City or town) (County) (State)

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

While at work? no (Specify type of place) (If means of injury)

23. Signature Phos. P. Hoffman 5

Address St. Louis Mo Date signed 10/29/40

Duration  
Physician  
Underline the cause to which death should be charged statistically.

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

**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

*W. L. Wheeler*

Licensed Embalmer No. *3008*

P. O. Address *Pacific Mo*

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 293

Primary Registration District No. 4177

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

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

1. PLACE OF DEATH:

(a) County. Franklin  
(b) City or town. Franklin  
(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.  
In this community. \_\_\_\_\_ (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME John Allen Kern

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

4. Sex. m 5. Color or race w 6. (a) Single, widowed, married, divorced. s

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

7. Birth date of deceased. may 9 1917  
(Month) (Day) (Year)

8. AGE: Years 23 Months 5 Days 11 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. \_\_\_\_\_ (State or foreign country)

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

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

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

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

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

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

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

19. (a) Oct 21 1940 (b) Mary B. Goss  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

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

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury. \_\_\_\_\_

23. Signature Thos. J. Shaffer (M. D. or other) \_\_\_\_\_

Address Sullivan Date signed. \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

