

1 AUG 11 1941

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

25850
Do not use this space.

1. PLACE OF DEATH *Pike*
 (a) County *Pike* Registration District No. *681*
 (b) Township *Calamus* Primary Registration District No. *5909A*
 (c) City *Rural* (d) Street No. *1* St. *1*
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Ernest Herman Eugene Hert*
 (a) Residence, No. *R.F.D. Clearville Mo* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Boy* 4. COLOR OR RACE *Black* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *15- 15- 0- 0-*

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *X*
 9. Industry or business in which work was done, as 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) *R.F.D. Clearville Mo*

FATHER
 13. NAME *Red Hert*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *New Hartford Mo*

MOTHER
 15. MAIDEN NAME *Malindy Webster*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Lincoln Co Mo*

17. INFORMANT (ADDRESS) *Red Hert R.F.D. Clearville Mo*

18. BURIAL, CREMATION, OR REMOVAL
 PLACE DATE

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

20. FILED 19

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 14th 1941*

22. I HEREBY CERTIFY, that I attended deceased from *June 26th 1941* to *July 14th 1941*
 I last saw him alive on *July 14th 1941*. Death is said to have occurred on the date stated above, at *1:00 P.M.*
 The principal cause of death and related causes of importance were as follows:
Acute Bronchitis
158
 Date of onset *June*

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury
 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) *C. L. B. Smith* M. D.
 (Address) *Paysonville Mo*

Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PERMANENTLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

1 X18605

RECEIVED

District Health Officer No. 10

District File Number 844-1448

Date Filed AUG 6 1941

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.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25850

Registration District No. 181

Primary Registration District No. 5909a

Registrar's No. _____

1. PLACE OF DEATH

(a) County Pike

(b) City or town Columb Rival
(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 _____ 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ernest H. E. Kerr

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day _____ year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

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

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

Immediate cause of death _____ Duration _____

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

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

Due to _____

Due to _____

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

Other conditions _____ (include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings: _____

11. Industry or business _____

Of operations _____

12. Name _____

Of autopsy _____

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

Underline the cause to which death should be charged statistically.

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) Buried (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Colabenny Mo

18. (a) Signature of funeral director W. W. Feuster

(b) Address Colabenny Mo

19. (a) July 14 (b) Martha J. Jamer (Registrar's signature)

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)

(b) 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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

