DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 14 1941

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 32674

Registration District No. 793 — Primary Registration District No. 6036 — Registrar's No. 8

X26390

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

**1. PLACE OF DEATH:**

(a) County Saline

(b) City or town ~~Mt Leonard~~ Blumwood

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether

In this community life years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Saline 97

(c) City or town Mt Leonard 0

(If outside city or town limits, write "RURAL") 0

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James Kerr

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Nelly McGinnis Kerr

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

7. Birth date of deceased Sept. 20 1859 (Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 3 If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business General Store

FATHER
12. Name Dan Kerr
13. Birthplace Ireland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rose Kerr
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nelly Kerr

(b) Address Mt Leonard Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25 41 (Month) (Day) (Year)

(c) Place: burial or cremation Shackelford

18. (a) Signature of funeral director Don Short

(b) Address Marshall Mo.

19. (a) Sept. 25-41 (Date received local registrar) (b) Mattie Wessler (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 23 year hour minute M.

21. I hereby certify that I attended the deceased from Sept 15, 1941, 19 to Sep. 23, '41, 19; that I last saw him alive on Sep. 22, '41, 19; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral haemorrhage | 10 da |
| Due to: Hypertension | |
| Due to: | |
| Other conditions: Myoacrditis (Include pregnancy within 3 months of death) | 1yr duration |

Major findings:
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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature L. S. James, M.D. (M. D. or other)

Address Blackburn Mo. Date signed 9-24-'41

764 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number 18-3-41
Date Filed

## 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 Donald W. Sloat

Licensed Embalmer No. 3757

P. O. Address Marshall

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

No. 2B
-8-21-41
I X29288

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State File No. 32674

Registration District No. 793 Primary Registration District No. 6036 Registrar's No.

**1. PLACE OF DEATH:**

(a) County: Saline

(b) City or town: Mt Leonard
(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 years, months or days)

In this community

**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: James Kerr

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: M

6. (b) Name of husband or wife: Nelly McHenry Kerr

6. (c) Age of ~~husband~~ or wife if alive: 59 years

7. Birth date of deceased: Sept (Month) 20 (Day) 1859 (Year)

8. AGE: Years 82 Months 0 Days 5 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept Day 3 year 1941 hour 8 minute 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.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY