

FILED MAY 23 1944  
Registration District No. 1787

Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Lakeside Hospital  
(If not in hospital or institution, write street number or location) 33 hours  
(d) Length of stay: In hospital or institution 33 hours (Specify whether  
In this community 18 months years, months or days)

3. (a) PRINT FULL NAME Mrs. Helen E. Kerr  
3. (b) If veteran, name war no  
3. (c) Social Security No. 506-87-0835

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife F. B. Kerr 6. (c) Age of husband or wife if alive 32 years  
7. Birth date of deceased: October 6th 1912  
(Month) (Day) (Year)

8. AGE: Years 31 Months 7 Days 8  
If less than one day hr. min.

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

10. Usual occupation At home

11. Industry or business

MOTHER FATHER  
12. Name C. A. Fughart  
13. Birthplace unk 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Bessie Hill  
15. Birthplace Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant F. B. Kerr  
(b) Address North Kansas City, Route # 10

17. (a) Burial (b) Date thereof 5-18-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Freeman Mortuary  
18. (a) Signature of funeral director 104 West 42nd Street  
(b) Address

19. (a) 5-15-44 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

2. -USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Clay 24  
(c) City or town North Kansas City...Rural 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. Route # 10  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14th  
year 1944 hour 9 minute 45 a.m.

21. I hereby certify that I attended the deceased from May 12  
1944 to May 14 1944  
that I last saw her alive on May 14 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Complete cardiac and respiratory failure  
Due to Toxemia

Due to General peritonitis 3 days  
Salpingitis  
Other conditions 39a  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations no operation  
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:  
(c) 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? (Specify type of place)  
23. Signature Charles Berry (M.D. or other) DO  
Address Chambers Bldg Date signed 5-15-44

*12. 4. 1930  
D. 10:30 AM  
Chapman  
Chapman  
Chapman*

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