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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 13 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Kerr

State File No. 20368

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 501

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: 626 E. Page 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 30 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 626 E. Page 6
(If rural, give location)

(e) Citizen of foreign country? 6 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mae Salts

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Allen A. Slats

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

7. Birth date of deceased Dec. (Month) 2 (Day) 1893 (Year)

8. AGE: Years 51 Months 6 Days 20 If less than one day hr. min.

9. Birthplace Near, Ash Grove (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Ed W. Elson
13. Birthplace UNK (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Mary B. Jones
15. Birthplace Near, Ash Grove (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Allen A. Salts
(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Ash Grove, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 6-27-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22
year 1945 hour 4 minute 50p. M.

21. I hereby certify that I attended the deceased from June 20, 1945 to June 22, 1945
that I last saw him alive on June 22, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Shock
Pernicious anemia

Due to Kidney Trouble

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations no

Of autopsy no

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?
(Specify type of place)

While at work? no (e) Means of injury none

23. Signature U F Kerr (M. D. or other)

Address Springfield, Mo Date signed July 25 1945

(Licensed Embalmer's Statement on Reverse Side)

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 L. Dorlin Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield 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.