

S. No. 2
M-5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4594**

FILED FEB 18 1947

Registration District No. **291** Primary Registration District No. **4200** Registrar's No. **97**

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Ash Grove

(c) Name of hospital or institution: _____

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

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 60 years (Specify whether)

years, months or days

3. (a) PRINT FULL NAME FRANK E. KERR

3. (b) If veteran, _____ **3. (c) Social Security** _____

name war _____ No. _____

4. Sex Male **5. Color or race** White

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

6. (b) Name of husband or wife Jennie Smith **6. (c) Age of husband or wife if** _____

alive, 64 years

7. Birth date of deceased November 5 1869

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>3</u>	<u>5</u>	_____ min.

9. Birthplace Fairfield Iowa

(City, town or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business Farm

12. Name John Kerr

13. Birthplace _____

(City, town, or county) (State or foreign country)

14. Maiden name Alice Curry

(City, town, or county) (State or foreign country)

15. Birthplace _____

(City, town, or county) (State or foreign country)

16. (a) Informant Richard H. Kerr

(b) Address Ash Grove Mo

17. (a) Burial _____ **(b) Date thereof** 2-13-47

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ash Grove Cemetery

18. (a) Signature of funeral director Gene A. Burn

(b) Address Ash Grove Mo

19. (a) 2/15/1947 **(b) Irene H. Wilson**

(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene

(c) City or town Ash Grove

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

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

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 10th

year 1947 hour 5 minute 35 AM

21. I hereby certify that I attended the deceased from June 6

_____ 1946, to Feb-10 1947.

that I last saw him alive on Feb-9- 1947.

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage (Right) Duration 20 hrs

Due to Hypertension 7:10 pm

Due to _____

Other conditions Cerebral Hemorrhage (R) Jan-22-47

(Include pregnancy within 3 months of death)

Major findings: 83%

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury Push

23. Signature Dr. Charles H. Orr (M. D. or other) _____

Address Ash Grove Mo Date signed 2/14/47

RECEIVED

Greene County Health Office

County File Number 41-2-18

Date Filed 2-17-47

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 Warren D. Hoblett

Licensed Embalmer No. 4005

P. O. Address Oak Grove, Md.

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.