

FILED JUL 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24751

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 101

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
419 Mechanic Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 41 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston
(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No. 419 Mechanic Street
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles Frederick Kerns

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Ida Kerns
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 21 1876
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 23
If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Fireman

11. Industry or business Slifer's Laundry

12. Name Jacob Kerns

13. Birthplace DeKalb County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Susie Conover

15. Birthplace Davies County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant A. R. Kerns

(b) Address Elmo, Missouri

17. (a) Burial (b) Date thereof 7-16-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gibbon Cemetery

18. (a) Signature of funeral director Norman Funeral Home

(b) Address Chillicothe, Missouri

19. (a) July-14-47 (b) Frances O. Neill
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14th
year 1947 hour 11 minute 25 P. M.

21. I hereby certify that I attended the deceased from March 2 1946 to July 14 1947
that I last saw him alive on July 14 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of mouth
Duration 6 mo

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:

(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? _____

While at work _____
(Specify type of place) (e) Means of injury _____

23. Signature J. J. Russell (M.D. or other) _____
Address Chillicothe, Mo. Date signed 7/14/47

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

MOTHER FATHER

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

E. L. R. R. R.

Licensed Embalmer No. **4036**

P. O. Address **Chillicothe, 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.