

FILED JUL 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24786

Registration District No. 198

Primary Registration District No. 4311

Registrar's No. 1

1. PLACE OF DEATH:

(a) County MACON  
(b) City or town Callao  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 75 year (Specify whether)  
In this community 75 year (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI, (b) County MACON  
(c) City or town Callao  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME William Kerr

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: \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: 7-15-1871  
(Month) (Day) (Year)

8. AGE: Years: 75 Months: 11 Days: 13 If less than one day hr. min.

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

10. Usual occupation: Retired

11. Industry or business: \_\_\_\_\_

MOTHER FATHER

12. Name: HANNISON KERR

13. Birthplace: Ohio (City, town, or county) (State or foreign country)

14. Maiden name: MARION BRAMMER

15. Birthplace: MISSOURI (City, town, or county) (State or foreign country)

16. (a) Informant: Mr Lee Kern

(b) Address: Callao MO

17. (a) Burial (b) Date thereof: 6-30-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Street Home Callao MO

18. (a) Signature of funeral director: KERR & EDWARDS

(b) Address: Callao MO

19. (a) 7-8-47 (b) Mrs. Helma Baker  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 28  
year 1947 hour 4 minute 12 M.

21. I hereby certify that I attended the deceased from June 27 1947 to June 28 1947  
that I last saw him alive on June 28 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Myocarditis Duration 2 Day

Due to: \_\_\_\_\_  
Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: NO

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 \_\_\_\_\_

23. Signature: Dr. West (M. D. certificate)  
Address: New Orleans Date signed: 7/3/47

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

RECEIVED  
District Health Officer No. 10  
District File Number 7-47-190  
Date Filed JUL 15 1947

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 H. J. Gilleland

Licensed Embalmer No. 4019

P. O. Address Columbia, 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.