S. No. 2
M—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 20 1947

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

36659

State File No. 0

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 2179

**1. PLACE OF DEATH:**

(a) County: St. Louis

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

(c) Name of hospital or institution: 569 St. Joseph Street
(If not in hospital or institution, write street number or location)

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

In this community: 20 years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: St. Louis 96

(c) City or town: Florissant 10
(If outside city or town limits, write "RURAL")

(d) Street No.: 569 St. Joseph Street 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME: HENRY KERBY

3. (b) If veteran, name war: Nil

3. (c) Social Security No.: None

4. Sex: M 0

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife: Sarah Jane

6. (c) Age of husband or wife if alive: 71 years

7. Birth date of deceased: February 21, 1868 (Month) (Day) (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 7 | 9 | hr. min. |

9. Birthplace: ? (City, town, or county) Iowa (State or foreign country)

10. Usual occupation: Coal Miner

11. Industry or business: Retired

FATHER
12. Name: Unknown 9
13. Birthplace: (City, town, or county) (State or foreign country) 1

MOTHER
14. Maiden name: Unknown 9
15. Birthplace: (City, town, or county) (State or ~~foreign~~ country) 1

16. (a) Informant: Mable Warner
(b) Address: 569 St. Joseph. Florissant

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 10-4-47 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Matthews Cemetery

18. (a) Signature of funeral director: A.W. McLaughlin
(b) Address: 2301 Lafayette Avenue

19. (a) 10-7-47 (Date received local registrar) (b) [signature] (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month October day 2nd year 1947 hour minute M.

21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....; that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Cause unknown | |
| Due to: | |
| Due to: 200 | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations: | |
| Of autopsy: | |

PHYSICIAN — Underline the cause of 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? Means of injury 0

23. Signature [signature] (M. D. or Coroner)

Address: Commissioner of Health Date signed: 10-14-47

Jefferson City Printing Co.

(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.....C W Cooper.....

Licensed Embalmer No.....3830.....

P. O. Address.....2301 Lafayette.....

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.