

FILED APR 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13058
1714

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Liberty	
c. LENGTH OF STAY (in this place) 1 Day		d. STREET ADDRESS (If rural, give location) Liberty R 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION Osteopathic Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Lydia b. (Middle) Margarette c. (Last) Kerr			4. DATE OF DEATH (Month) (Day) (Year) April 10 1950			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 7-1897	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? US.	

13a. FATHER'S NAME Henry Huxoll		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Fred Kerr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred Kerr Liberty R 3 Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute nephritis		INTERVAL BETWEEN ONSET AND DEATH 4 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocarditis		2 yrs.
	DUE TO (c) Pericarditis (chronic)		4 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4116X			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4-9**, 19**50**, to **4-10**, 19**50**, that I last saw the deceased alive on **4-9**, 19**50**, and that death occurred at **12:15 A.**, from the causes and on the date stated above.

23a. SIGNATURE Clyde M. Smith (Degree or title) D.O.	23b. ADDRESS Liberty Mo.	23c. DATE SIGNED 4-10-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE April-10-50	24c. NAME OF CEMETERY OR CREMATORY Fairview
24d. LOCATION (City, town, or county) (State) Liberty, Mo.		

DATE REC'D BY LOCAL REG 4-12-50	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Church-Cremer Co. Liberty Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *John Lenherg*.....

Licensed Embalmer No. *4448*.....

P. O. Address *Liberty 070*.....

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.