

RECORD DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021148

FILED VS MAY 25 1960

318 Primary Registration District No. 1003 Registrar's No. 5202

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Scyler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo		c. CITY OR TOWN Huntsville	
Length of stay in 1b 6 days		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's		d. STREET ADDRESS (If outside, give location) Star Route	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last John William Kerr			4. DATE OF DEATH Month Day Year 5 16 60			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-8-59	9. AGE (last birthday) 10 Mo.	IF UNDER 1 YEAR Months 10 Days 8	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Rushville, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME Donald Kerr		13b. MOTHER'S MAIDEN NAME Doris Janssen		14. NAME OF HUSBAND OR WIFE None		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Roma Welp St. Louis Children's		
				Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Accumulation of and aspiration of mucus</u> DUE TO (c) <u>Bilateral Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute osteolytic lesion</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 491x	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>May 10, 1960</u> to <u>May 16, 1960</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>May 16, 1960</u> Death occurred at <u>3:55 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Leola W Peterson MD</u>		22b. ADDRESS <u>500 So. Kingshighway Blvd.</u>	
22c. DATE SIGNED <u>5-16-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-17-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Augusta, Illinois.</u>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 17 1960</u>	
		26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

21803

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596  
P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.