

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017699

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 328 Primary Registration District No. 6112 Registrar's No. 21

FILED APR 17 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <u>Scott</u> | b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Keleso</u> | a. STATE <u>Missouri</u> | b. COUNTY <u>Scott</u> |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Keleso</u> | | c. CITY OR TOWN <u>Keleso</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u> | | d. STREET ADDRESS (If outside, give location) | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|-------------------------------------|------------------|------------------------|------------------|------------------|------------------|--------------|------------------|
| 3. NAME OF DECEASED (Type or print) | First <u>LEO</u> | Middle <u>AL045105</u> | Last <u>HERN</u> | 4. DATE OF DEATH | Month <u>Apr</u> | Day <u>2</u> | Year <u>1962</u> |
|-------------------------------------|------------------|------------------------|------------------|------------------|------------------|--------------|------------------|

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|--------------------|-------------------------------|---|-------------------------------------|----------------------------------|--|--|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 6, 1897</u> | 9. AGE (last birthday) <u>65</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u> | 11. BIRTHPLACE (City and state or country) <u>Keleso, Mo</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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|---------------------------------------|--|-----------------------------|
| 13a. FATHER'S NAME <u>John G Kern</u> | 13b. MOTHER'S MAIDEN NAME <u>Katy Hess</u> | 14. NAME OF HUSBAND OR WIFE |
|---------------------------------------|--|-----------------------------|

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT <u>Mrs. Wm Corvick</u> | Address <u>Scott City, Mo</u> |
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| 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>Cardio. Renal Vas Calar. Surm.</u> | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | 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 |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) |
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|---|---|--|------------------------------|--------------|-------------|
| 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 checked="" 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 _____ |
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| 21. I attended the deceased from <u>April 1-1962</u> to <u>April 2 1962</u> and last saw him alive on <u>March 1 1962</u> Death occurred at <u>7:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>Theodore Kern MD</u> | 22b. ADDRESS <u>Cape Girardeau Mo</u> | 22c. DATE SIGNED <u>4.3.62</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>4/6/62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Augustines</u> | 23d. LOCATION (City, town, or county) (State) <u>Keleso, Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>Bispling Loff-Ferris Home</u> | ADDRESS <u>Keleso Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>April 10-62</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs Fred Bishop</u> |
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USE BLACK INK OR TYPEWRITER RIBBON

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 _____
Signature of Student Embalmer

Signed *Alvin C. [Signature]*

Licensed Embalmer No. 44170

P. O. Address *Illmo 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.