

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Madison
Township Truetteville
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 538 File No. 34849
Primary Registration District No. 5724 Registered No. 113

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Frank Milton Berry

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH Nov 13, 1910
(Month) (Day) (Year)

DATE OF BIRTH Oct 22, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 29, 1910, to Nov 13, 1910, that I last saw him alive on Nov 6, 1910, and that death occurred, on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:

AGE _____ yrs. _____ mos. 22 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

Gastritis
1180
158
_____. (Duration) _____ yrs. _____ mos. 18 ds.

OCCUPATION (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Madison Co., Mo.

PARENTS
NAME OF FATHER Wm. Berry
BIRTHPLACE OF FATHER (City or town, State or foreign country) Madison Co., Mo.
MAIDEN NAME OF MOTHER Arabella Stevens
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Madison Co., Mo.

Contributory (SECONDARY) Battle-feeding
(Duration) _____ yrs. _____ mos. 21 ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Dave Berry

(Signed) D. D. [Signature] M. D.
Nov 14, 1910 (Address) Caldwells

(ADDRESS) Caldwells Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. in the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

Filed Nov 14, 1910 REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL Nov 14, 1910
UNDERTAKER _____ ADDRESS _____

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County.....
 Township..... or.....
 Village..... or.....
 City..... (NO.....).....
 Registration District No..... File No.....
 Primary Registration District No..... Registered No.....
 St. 7 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month)..... / (Day)..... / (Year).....	
AGE yrs. mos. ds.	IF LESS than 1 day, hrs. or min.?

OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
 (City or town, State or foreign country)

NAME OF FATHER

BIRTHPLACE OF FATHER
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed

191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month)....., 191..... (Day)..... (Year).....

I HEREBY CERTIFY, that I attended deceased from....., 191....., to....., 191..... that I last saw h..... alive on....., 191..... and that death occurred, on the date stated above, at..... m. The CAUSE OF DEATH* was as follows:

Contributory

(SECONDARY)

(Signed)

191..... (Address)

M. D.

(Duration)..... yrs. mos. ds.

(Duration)..... yrs. mos. ds.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW:

County Madison
 Township Twelve Mi.
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 538 File No. 34849

Primary Registration District No. 5726 Registered No. 113

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Frank Melton Berry

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)

DATE OF DEATH Nov 13, 1910
(Month) (Day) (Year)

DATE OF BIRTH Oct 2, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 27, 1910, to Nov. 13, 1910, that I last saw him alive on Nov 6, 1910, and that death occurred, on the date stated above, at 1 P. m.

AGE 22 yrs. 22 mos. 22 ds.
IF LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

Gastritis

BIRTHPLACE (City or town, State or foreign country) Madison, Mo.

(Duration) ___ yrs. ___ mos. 18 ds.

PARENTS NAME OF FATHER Wm Berry

Contributory Bottle fed
(SECONDARY)

BIRTHPLACE OF FATHER (City or town, State or foreign country) Madison, Mo.

(Duration) ___ yrs. ___ mos. 21 ds.

MAIDEN NAME OF MOTHER Arabella Stevens

(Signed) J. A. Meyers M. D.
Nov. 14, 1910 (Address) Caldwaters Mo

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Madison, Mo.

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) Frank Berry

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

(ADDRESS) Caldwaters Mo

Where was disease contracted If not at place of death?

Filed Nov 14 1910

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL St. Stephens Cemetery DATE OF BURIAL Nov. 14, 1910

UNDERTAKER _____ ADDRESS _____

REGISTRAR

All information called for must be written on this Supplementary Certificate.

N. B.—Accuracy of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile, factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)