N. B.—Every item 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.

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

PLACE OF DEATH

County Scott

Township Sylvania
or
Village
or
City (NO. St.; Ward)

Registration District No. 820 File No. 231124

Primary Registration District No. 6069 Registered No. 77

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

FULL NAME Ralph Edward Berry

PERSONAL AND STATISTICAL PARTICULARS

SEX: male
COLOR OR RACE: white
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): at home

DATE OF BIRTH: July (Month) 16 (Day), 1914 (Year)

AGE: yrs. mos. 1 ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country): Scott Co

PARENTS
NAME OF FATHER: George Thomas Berry
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky
MAIDEN NAME OF MOTHER: Christine Wallace
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Indiana

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. T. Berry
(ADDRESS) Oran Mo.

Filed 9/22, 1914. [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 17 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from July 16th, 1914, to July 16th, 1914, that I last saw him alive on July 17, 1914, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Patent foramen ovale
157C (Duration) yrs. 1 mos. 1 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) W. H. Wenevat M. D.
7/17, 1914 (Address) Oran, 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

PLACE OF BURIAL OR REMOVAL: Oran
DATE OF BURIAL: July 18, 1914
UNDERTAKER: T. S. Hemmer
ADDRESS: Oran

PLACE OF DEATH

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

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ _____ St.; _____ 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), 1 _____ (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)

PARENTS

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) _____

_____, 191__, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day), 191__ (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:

_____

_____

_____

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

Contributory (SECONDARY) _____

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

(Signed) _____ M. D.

_____, 191__ (Address) _____

*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 _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191__
UNDERTAKER	ADDRESS

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 ...

clature of the American Medical Association.)