LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH
County Greene
Township Smith Campbell
or
Village
or
City SPRINGFIELD Mo. (NO. R F D # 9 St.; Ward)

Registration District No. 318 File No. 39174
Primary Registration District No. 5440 Registered No. 830

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

2 FULL NAME Daisy A Berry.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married
6 DATE OF BIRTH Feb. (Month) 2 (Day), 1877 (Year)
7 AGE 41 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?
8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)
9 BIRTHPLACE (City or town, State or foreign country) Illinois

PARENTS
10 NAME OF FATHER Benj Smith.
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ny.
12 MAIDEN NAME OF MOTHER Anna Omer.
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. N. Berry.
(Address) R # 9 Box 10 d

15 Filed NOV 11 1918, 191 Edwin F. James Registrar
Dollie B Johnson Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 10th (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 14, 1918, to Nov 10, 1918, that I last saw her alive on Oct 18", 1918, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of lungs
23A
78
(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(Duration) yrs. mos. ds.

4 (Signed) Wm A Coy M. D.
11-11, 1918 (Address) Springfield Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL Kirksville Mo.
DATE OF BURIAL Nov. 11, 1918
20 UNDERTAKER Parson Mud. Co.
ADDRESS 410 South

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE 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.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed..... ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 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.

18 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.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

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.