

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.

1 PLACE OF DEATH

County OsageTownship Center

or

Village Greenfield

or

City Greenfield

(NO.)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 237File No. 5238Primary Registration District No. 4144

Registered No.

St. Ward)

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

2 FULL NAME Raymond Berry

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH July 9, 1918
(Month) (Day) (Year)

7 AGE 7 yrs. 10 mos. 14 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) Franklin Co Mo

PARENTS
10 NAME OF FATHER Leonard Berry
11 BIRTHPLACE OF FATHER
(City or town, State or foreign country) Franklin Co Mo
12 MAIDEN NAME OF MOTHER Marion Berry
13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Franklin Co Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leonard Berry
(Address) Greenfield, Mo

15 Filed July 10, 1919 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 21, 1919
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 21, 1919 to Feb 19, 1919, that I last saw him alive on Feb 19, 1919, and that death occurred, on the date stated above, at 4 p. m.
The CAUSE OF DEATH* was as follows:
Lobular Pneumonia

107A 9m
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 8 (Duration) yrs. mos. ds.
(Signed) J. R. Ryan M. D.
Feb 21, 1919 (Address) Greenfield

*State the Disease Causing Death, or, in death 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 Greenfield DATE OF BURIAL 7/14/19
20 UNDERTAKER Long & Co ADDRESS Greenfield

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

1 PLACE OF DEATH

County

Township Registration District No.

or

Village Primary Registration District No.

or

City (NO St. Ward)

File No.

Registered No.

[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)
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6 DATE OF BIRTH (Month) 1 (Day) 191 (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)

10 NAME OF FATHER (City or town, State or foreign country)

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

12 MAIDEN NAME OF MOTHER (City or town, State or foreign country)

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 , 191

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) 191 (Day) 191 (Year)

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

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
 (Signed) (Duration) yrs. mos. ds.
 M. D. 191 (Address)

*State the Disease Causing Death, or in death 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