

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

Do not use this space.

28322

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No. **28322**

Township.....

Primary Registration District No. **1003**

Registered No. **7795**

City *St. Louis, Mo.*

(No. *500 S. Kings Highway*, *St. Louis Children's Hosp.*, *P.C. Ward*)

2. FULL NAME

Frank Robert Berry

(a) Residence. No. *321 Central Ave. Collinsville, Mo.*

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male *White* *-*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *5-21-1926*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>1</i>	<i>3</i>	<i>10</i>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Collinsville, Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Frank Berry*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Collinsville, Mo.*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Charlotte Strubbs*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Collinsville, Mo.*
(STATE OR COUNTRY)

14. INFORMANT *Informant*
(Address) *580 S. Kings Highway*

15. FILED *SEP -1 1927*
Male Part of

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9-1-1927*

17. I HEREBY CERTIFY, That I attended deceased from *8-31-27* to *9-1-27*, that I last saw him alive on *8-31-27*, and that death occurred, on the date stated above, at *6:10 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ileo-Colitis, Acute

CONTRIBUTORY (SECONDARY) *1/3* (duration) *5* yrs. *3* mos. *5* ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *No.* DATE OF.....

WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS? *Phys. Exam -*

(Signed) *Kessie G. Berry* M. D.

(Address) *St. Louis Children's Hospital*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Collinsville, Mo. DATE OF BURIAL *Sept 4 1927*

20. UNDERTAKER

Schroepfel Und. Co. ADDRESS *Collinsville, Mo.*

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.

