

JUL 26 1928

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

Do not use this space.

21285

1. PLACE OF DEATH

County *Miss*

Registration District No. *566*

File No. *21285*

Township

Primary Registration District No. *3030*

Registered No. *36*

City *Charleston Mo* (No. *.....*)

St. *.....* Ward *.....*

2. FULL NAME

Berlie May Kepheler

(a) Residence. No. *Charleston Mo St.* Ward *.....*

(Usual place of abode)

(if nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 5th 1917*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *1 16*

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER *unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *unknown*

12. MAIDEN NAME OF MOTHER *Louie Kepheler*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *State of Miss*

14. INFORMANT *Jimmy Kepheler*
(Address) *Charleston Mo*

15. FILED *June 22nd 1928* REGISTRAR *J. S. Dorman*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 21st 1928*

17. I HEREBY CERTIFY That I attended deceased from *May 19 1928* to *June 17 1928* that I last saw *h.l.a.* alive on *May 19 1928* and that death occurred, on the date stated above, at *9:00 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
3 7 38 (duration) yrs. mos. da.
CONTRIBUTORY *None known* (SECONDARY) (duration) yrs. mos. da.

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? *Clinical symptoms*

(Signed) *H. W. Chapman* M. D.

, 19 (Address) *Charleston Mo*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Oak Grove Cem* DATE OF BURIAL *6-22-28*

20. UNDERTAKER *Private* 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.

DEPARTMENT RECORD

