

JAN 23 1929

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

Do not use this space.

*Dr. J. J. Grier*

1. PLACE OF DEATH

County *Cape Girardeau* Registration District No. *125*  
Township *Southeast Mo. Hsp.* Primary Registration District No. *3009*  
City *Cape Girardeau* (No. ....) St. .... Ward .....

File No. *39715*  
Registered No. *1291*  
St. .... Ward .....

2. FULL NAME

*Berry, Mrs. Lillian*  
(a) Residence. No. *Hickory 710* 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. *1 1/2* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Caucasian* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *12/29/1900*

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

8. OCCUPATION OF DECEASED

(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) *Piggott Ark* (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Abott, Mike*

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

12. MAIDEN NAME OF MOTHER *Brown, Angeline*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Piggott Arkansas* (STATE OR COUNTRY)

14. INFORMANT *Kelchert, Mary (sister)* (Address) *Lidson, Mo.*

15. FILED *12/27 1928* *W. C. Dempster* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12/27 1928*

17. I HEREBY CERTIFY That I attended deceased from *12/25* 1928, to *12/27* 1928 that I last saw him alive on *12/25* 1928, and that death occurred, on the date stated above, at *12/25 (P)* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Sunshot wound of abdomen*

*173*

(duration) yrs. mos. *2* ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *12/25-28*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *operation*  
(Signed) *George Walker* M. D.  
*12/27, 1928* (Address) *Cape Girardeau*

\*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 *Piggott Ark Burial* DATE OF BURIAL *Dec 28 1928*

20. UNDERTAKER *Walthu U. S. Co* ADDRESS *Cape Gir. 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.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Cape Girardeau Registration District No. 125 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3009 Registered No. 1291  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Lizva Berry  
 (a) Residence. No. \_\_\_\_\_ 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 30 - 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
29 1 7

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

14.

INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

15.

FILED 2/15/29 W. K. Kasper REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/27 1928

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Gunshot wound of abdomen (Homicide)

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

\_\_\_\_\_, 19\_\_\_\_ (Address)

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-39715