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

Do not use this space.

400

File No. ____
Registered No. 18

FEB 18 1931

1. PLACE OF DEATH
County: Calloway
Registration District No.: 104
Township: ____
Primary Registration District No.: 3008
City: Fulton (No. ____ St. ____ Ward)

2. FULL NAME: Lucy Berry
(a) Residence. No. Calloway Co. St., ____ Ward. ____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 20 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)
F	W	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) No information

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
	56	+	+	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(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) Missouri

PARENTS
10. NAME OF FATHER No information
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ____
(STATE OR COUNTRY) No information
12. MAIDEN NAME OF MOTHER No information
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ____
(STATE OR COUNTRY) No information

14. INFORMANT State hospital records
(Address) Fulton Mo

15. Filed Jan. 21, 1931 R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jany. 20 - 1931

17. I HEREBY CERTIFY, That I attended deceased from Nov. - 20 -, 1930, to Jany. 20 -, 1931 that I last saw her alive on Jany. 20 -, 1931, and that death occurred, on the date stated above, at 9:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculous laryngitis
VS A
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) Pulmonary Tuberculosis
(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) T. R. Frazes, M. D.
1-21-1931 (Address) Fulton State 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: Maloney Cemetery
DATE OF BURIAL: Jan. 21 1931

20. UNDERTAKER: Leo G. Wallace
ADDRESS: Fulton, Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.