

MAR 6

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

Do not use this space.

4575

1. PLACE OF DEATH

County *Wright*
Township *Wright*
City *Wright*

Registration District No. *Wright 908*
Primary Registration District No. *6222*

File No. _____
Registered No. *3*
St. _____ Ward _____

2. FULL NAME

George Berry

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred *18* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 8-1859*

7. AGE YEARS *75* MONTHS *11* DAYS *29* If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Farmer*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St Genevieve Co. Mo*

13. NAME *Thirane Berry*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

17. INFORMANT *Mrs. Hester Berry* (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE *Done State* DATE *1-9-1922*

19. UNDERTAKER *man* (ADDRESS) _____

20. FILED *48* 19 *33* *J. A. Ryland* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 7 1922*

22. I HEREBY CERTIFY That I attended deceased from *12/15* - *1921* to *1/7* - *1922*. I last saw him alive on *1/5* - *1922*. Death is said to have occurred on the date stated above, at *3:40* a.m.

The principal cause of death and related causes of importance were as follows:

Flu & Bronchial pneumonia
Other contributory causes of importance: *MI*

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) *R. A. Ryan*, M. D.
(Address) *Wright*

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.

