

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

Do not use this space.

33407

1. PLACE OF DEATH

County Sullivan
Township Morris
City (No.)

Registration District No. 849
Primary Registration District No. 6125-

File No. _____
Registered No. 23
St. _____ Ward _____

2. FULL NAME David Berry

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

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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF <u>Phoebe Wood</u> (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>2-11-18</u>		
7. AGE <u>86</u>	YEARS <u>5</u>	MONTHS <u>22</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>		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) Ill.

13. NAME Wm Berry
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

15. MAIDEN NAME Elizabeth Alexander
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT Mrs Floyd Cleeton
(ADDRESS) Wilmington

18. BURIAL, CREMATION, OR REMOVAL
PLACE Green Castle DATE 8-14 1936

19. UNDERTAKER Glenn E. Kent
(ADDRESS) Green City, Mo.

20. FILED Aug 8 1936 Virginia Gibson
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 3 - 1936

22. I HEREBY CERTIFY, That I attended deceased from July 15, 1936, to July 15, 1936

I last saw h. alive on July 15, 1936 Death is said

to have occurred on the date stated above, at 10 A. M.

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

Chronic Nephritis
myocarditis

Date of onset
1935
1935

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? None Was there an autopsy? No

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? No

If so, specify _____

(Signed) Carl Erickson, M. D.

(Address) Milan, Mo.

