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.

I X12004

SEP 10 1937

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

29338
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 791
(b) Township ..... Primary Registration District No. 1003 Registered No. 7971
(c) City St. Louis, Mo. (d) Street No. 3610 a N. Newstead Ave. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Catherine Berkley
(a) Residence, No. 3610 a N. Newstead Ave. St. 10
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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 William Berkley

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 13, 1871

7. AGE: 35 YEARS 66 MONTHS 2 DAYS 11 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as 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. Louis, Mo.

FATHER
13. NAME Joseph Byron
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER
15. MAIDEN NAME Mary Duhigg
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) William Berkley 3610a N. Newstead Ave.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary DATE 8/27/37 19

19. FUNERAL DIRECTOR (ADDRESS) Stroot Carroll Und. Co. 4600 Natural Bridge Ave.

20. FILED AUG 25 1937 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 24, 1937

22. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1937, to Aug. 24, 1937
I last saw her alive on Aug 24, 1937. Death is said to have occurred on the date stated above, at 5:30 a.m.
The principal cause of death and related causes of importance were as follows:

Encephalitis lethargica — Date of onset 7/20/37

17

Other contributory causes of importance:
Chronic hepatitis
Chronic cholecystitis
nonstones

Name of operation None Date of
What test confirmed diagnosis? Clinical 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 1
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Edward H. Smyth, M. D.
(Address) 705 Olive

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No. 2265

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Nil

..... L. E. .....

No. ..... or by ....., Registered Apprentice No. .....

working under my personal supervision.

Signed Frank H. Stroot

Licensed Embalmer No. 2265

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)