

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

34777
Do not use this space.

1. PLACE OF DEATH *Jackson* 2
 (a) County *Jackson* Registration District No. *399*
 (b) Township *Kear* Primary Registration District No. *1002*
 (c) City *Kansas City* (d) Street No. *924 E. 14th* 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 *Pauline Josephine Berry*
 (a) Residence, No. *924 East 14 St.* St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Fred Berry*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov-5-1905*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
33 11 15
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. *Homework*
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-20-38* 19
 22. I HEREBY CERTIFY, That I attended deceased from *Deputy Coroner* 19
 I last saw him/her alive *11:30 a.m.* Death is said to have occurred on the date stated above, at *11:30 a.m.*
 The principal cause of death and related causes of importance were as follows:
*Old deformity of left chest
Displacement of heart with hypertrophy & dilatation* Date of onset
 Other contributory causes of importance:
Pulmonary edema
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? *Yes*
 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) *Walter H. Butler* _____ M. D.
 (Address) *San Diego; K.P. Mo.*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kansas*
 FATHER 13. NAME *Wiles M. Winn*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Miss*
 MOTHER 15. MAIDEN NAME *Georgina Carter*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Miss*
 17. INFORMANT (ADDRESS) *E. B. Winn
5834 E-15 - Terrace*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Mt Moriah* DATE *Oct-22-1938*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Wm E Foster
918 Brooklyn B.C. Mo*
 20. FILED *10-22-38* *M. M. Crowe* Local Registrar.

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.