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.

FEB 21 1939

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

Do not use this space.

File No. 1999

Registered No. 8

1. PLACE OF DEATH

County Clay — Registration District No. 198

Township Fishing River — Primary Registration District No. 3011

City Excelsior Springs, Mo. (No. Veterans Administration, St. 3d Ward)

2. FULL NAME BERRY, Grant W.

(a) Residence, No. 509 So. Mulenix St., Ward. Kirksville, Mo.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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~~) Eva L. Berry

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 21, 1867

7. AGE: Years 71 — Months 1 — Days 0 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

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

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

10. Date deceased last worked at this occupation (month and year) unknown

11. Total time (years) spent in this occupation unknown

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kirksville, Mo. 6

FATHER

13. NAME James Berry

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER

15. MAIDEN NAME Emaline Spencer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wisc.

17. INFORMANT (ADDRESS) Hospital Records

18. BURIAL, CREMATION, OR REMOVAL

PLACE Kirksville, Mo. DATE 1-21-39 19

19. UNDERTAKER (ADDRESS) JOHN C. PRATHER Excelsior Springs, Mo.

20. FILED Jan 23, 1939 Rowena McCracken Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 21, 1939 19

22. I HEREBY CERTIFY, That I attended deceased from 9-28-38, 19..., to 1-21-39, 19...

I last saw him alive on 1-21-39, 19... Death is said to have occurred on the date stated above, at 8:45 m. a.m.

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

	Date of onset
Congestive heart failure	

Other contributory causes of importance:

Hypertensive heart disease	

Name of operation — Date of —

What test confirmed diagnosis? — 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?

If so, specify

(Signed) E. K. MOORE, MD, Clinical Director M.D.

(Address) Veterans Administration Facility Excelsior Springs, Mo.

RECEIVED
District Health Officer No. 8,

District File Number _____

Date Filed 2/7/39