

MAY 10 1939

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

13933

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Raw Primary Registration District No. 1002
(c) City Hannas City (d) Street No. Gen Hospital #2 Registered No. 1687
(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.
(If death occurred in hospital or institution, write its name instead of street and number)

2. PRINT FULL NAME MARY BERRY

(a) Residence, No. 813 East 8th 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 <u>Female</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Bert Berry</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 20, 1902</u>		
7. AGE	YEARS <u>37</u>	MONTHS <u>1</u>
	DAYS <u>25</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housework</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>at home</u>	
	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) <u>Little Rock Ark.</u>		
FATHER	13. NAME <u>Will Nash</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Little Rock Ark.</u>	
MOTHER	15. MAIDEN NAME <u>Ellen Gilchrist</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Little Rock Ark.</u>	
17. INFORMANT (ADDRESS) <u>Leola Humphrey 1961 N. 5th St.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Westlawn</u> DATE <u>April 22, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Nathan H. Thatcher 1520 N. 5th St.</u>		
20. FILED <u>Apr 22, 1939</u> <u>M. M. Brown</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-14-39 19

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said to have occurred on the date stated above, at 2:30 p.m. The principal cause of death and related causes of importance were as follows:
Pneumonia, mitral stenosis, acute & chronic pulmonary congestion
Date of onset

Other contributory causes of importance:

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) D. Russell Wilson, M. D.
(Address)

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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

B. L. Sheehan

Licensed Embalmer No.

2540

P. O. Address

2288 Vine St

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.