

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.

Dr. Townsend
Home Springs

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

32732
Do not use this space.

1. PLACE OF DEATH
50 (a) County JEFFERSON / Registration District No. 425
(b) Township MERAMEC / Primary Registration District No. 3580 Registered No. 12-38
(c) City ST. JOSEPH'S HILL INFIRMARY / (d) Street No. ST. JOSEPH'S HILL INFIRMARY 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 WILLIAM BERRY
(a) Residence, No. ST. JOSEPH'S HILL INF. 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 MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF EFFIE MOORE

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10 / 15 / 1870

7. AGE YEARS 68 MONTHS 10 DAYS 25 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. LABORER, RETIRED
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 5

12. BIRTHPLACE (CITY OR TOWN), DAYENPORT, IOWA (STATE OR COUNTRY)

FATHER 13. NAME THOMAS BERRY
14. BIRTHPLACE (CITY OR TOWN), OHIO (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME ELIZABETH MOORE
16. BIRTHPLACE (CITY OR TOWN), IOWA (STATE OR COUNTRY)

17. INFORMANT ST. JOSEPH'S HILL INFIRMARY (ADDRESS) Brother Bonaventure, O.S.F.

18. BURIAL, CREMATION, OR REMOVAL PLACE State Anatomical Board DATE 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jesse S. Sargent

20. FILED 9 Sept 29 1939 Dr. Townsend Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-9-39 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 31, 1939, to Sep 9, 1939
I last saw him alive on Sep 9, 1939. Death is said to have occurred on the date stated above, at 6:30 a.m.
The principal cause of death and related causes of importance were as follows:
Pneumo-pneumonia
Other contributory causes of importance: 107W

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) Jesse S. Sargent, M. D.
(Address) Church Mo.

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.