

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **45010**

Registration District No. **949**

Primary Registration District No. **6225**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Washington**
(b) City or town **Greene Springs**
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **4 years** (Specify whether)
years, months or days **11 2 15**

3. (a) PRINT FULL NAME **Berry Alexander**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **MA** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Grace** 6. (c) Age of husband or wife if alive **76** years

7. Birth date of deceased **April 12** (Month) **1861** (Day) (Year)

8. AGE: Years **78** Months **7** Days **7** If less than one day _____ hr. _____ min.

9. Birthplace **Coleco** (City, town, or county) **Illinois** (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Samuel Alexander**
13. Birthplace **Illinois** (City, town, or county) (State or foreign country)

14. Maiden name **Vanmeter**
15. Birthplace **not known** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Pike Alexander**

(b) Address **Green City Mo**

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation **Elm Woods Cem**

18. (a) Signature of funeral director **J. A. Stepper**

(b) Address **Marionville Mo**

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Wright**
(c) City or town **Greene Springs** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **18**
year **1939** hour **11:00** minute **55** M.

21. I hereby certify that I attended the deceased from **Nov 5**, 1939, to **Nov 18**, 1939; that I last saw him alive on **Nov 17**, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of stomach**
Hypostatic Pneumonia

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **F. E. Berthier M.D.** (Physician's signature)
Address **Nashville Tenn** Date signed **11/21/39**

State of Michigan
Department of Health
Bureau of Vital Statistics
Licensing Division
1000 State Capitol
Lansing, Michigan 48224
Tel. (313) 237-1234

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.

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

45010

Do not use this space.

1. PLACE OF DEATH *Wright*
(a) County *Wright* Registration District No. *949*
(b) Township *Union* Primary Registration District No. *6225-*
(c) City _____ (d) Street No. _____
(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 *Berry Alexander*
(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>m</i>	4. COLOR OR RACE <i>w</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>m</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE <i>78</i>	YEARS <i>7</i>	MONTHS <i>7</i>
DAYS <i>7</i>		If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation
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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
13. NAME		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
15. MAIDEN NAME		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE		DATE, 19
19. FUNERAL DIRECTOR (ADDRESS)		
20. FILED 19 <i>C. M. Howell</i> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov 18 1939*

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19.

I last saw h. alive on , 19. Death is said to have occurred on the date stated above, at m.

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

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 *F. E. Wagoner*, M. D.
(Signed) *Hester* (Address)

S-45010