

Registration District No. 399

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Mo  
(c) Name of hospital or institution: St. Joseph's Hosp  
(d) Length of stay: In hospital or institution 1 week  
In this community J. L. Berkebile  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay  
(c) City or town North Kansas City, (rural)  
(d) Street No. Route #4  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

J. L. BERKEBILE

(b) If veteran, name war No (c) Social Security No. 495-05-8023

4. Sex Male 5. Color or race Wht 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hellie Pearl 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased Aug 6 1876  
(Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 21 If less than one day \_\_\_\_\_ yr. \_\_\_\_\_ mo. \_\_\_\_\_ day

9. Birthplace: Iowa Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Staley Mfg Co.

11. Industry or business \_\_\_\_\_

12. Name Ephraim Berkebile

13. Birthplace Pa  
(City, town, or county) (State or foreign country)

14. Maiden name Susan Ewert

15. Birthplace Pa  
(City, town, or county) (State or foreign country)

18. (a) Informant's own signature Lester Berkebile

(b) Address no Kansas City, Mo

17. (a) Burial (b) Date thereof Mar 1-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Morton Funeral Home  
(b) Address No. Kansas City - Mo.  
19. (a) Feb. 29, 1940 N. M. Crone  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 27th  
year 1940 hour 2 minute A M.

21. I hereby certify that I attended the deceased from Jan. 10  
19 40 to Feb. 27 19 40  
that I last saw him alive on Feb. 26 19 40  
and that death occurred on the date and hour stated above.

Immediate cause of death Embolism in the splenic artery just anterior to the left gastric artery.

Due to Blood clot from the left auricle.

Due to 79a

Other conditions Auricular fibrillation.  
(include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy Above findings

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) (a) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 1408 Waldheim Bldg. Date signed 2-28-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39

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.....

Harold L. Posson....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Harold L. Posson.....

Licensed Embalmer No. 3605.....

P. O. Address North K. C. Mo......

**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.**