

Registration District No. 456Primary Registration District No. 4090Registrar's No. 34

1. PLACE OF DEATH:

- (a) County Cass
 (b) City or town Harrisonville
 (If outside city or town limits, write "RURAL" and name of township)
 (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 _____
 years, months or days

8. (a) PRINT FULL NAME Emma Alberta Berkstrom

8. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓

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

6. (b) Name of husband or wife George M Berkstrom 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Mar 19 - 1870
 (Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Home maker11. Industry or business ✓12. Name John E Smith13. Birthplace Illinois (City, town, or county) (State or foreign country)14. Maiden name Mary Ann Moon15. Birthplace Illinois (City, town, or county) (State or foreign country)16. (a) Informant Mrs. Clyde Blackwell(b) Address 319 Warren St. Pampa, Texas17. (a) Burial (b) Date thereof May 16 - 48
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation 81518. (a) Signature of funeral director RUNNENBURGER'S(b) Address HARRISONVILLE, MO.19. (a) 5/16/48 (b) Eidens
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass(c) City or town Harrisonville
(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 May 14 day _____
year 1948 hour 9 minute 35 A. M.21. I hereby certify that I attended the deceased from May 9,
1948, to May 14, 1948.that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis with Uraemic Coma
 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) _____23. Signature A J Smith (M. D. or other) mcayAddress H. Hill - Mo Date signed 14-48

FILED JUN 20 1948

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 _____

Ernest Runnenbryer

Licensed Embalmer No. _____

3368

P. O. Address _____

Harrisonville

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18128

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. Case 136

Primary Registration District No. 4090

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
(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 _____
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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.

3. (a) PRINCE FULL NAME

Emma Alberta BERKSTRESSER

4. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1940 hour _____ minute _____ M. _____

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

4. Sex _____

5. Color or race _____

6. (a) Single, widowed, married, divorced _____

(b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased

(Month) (Day) (Year)

Immediate cause of death _____

8. AGE:

Years

Months

Days

If less than one day

h. _____ min. _____

Due to _____

Due to _____

9. Birthplace _____

(City, town, or county)

(State or foreign country)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant _____

(b) Address _____

17. (a) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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 A. H. Scott (M. D. or other) _____

Address Harrisonville Date signed mo

SUPPLEMENTAL

