

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

22324
Do not use this space.

JUL 17 1940 2

1. PLACE OF DEATH
 (a) County Monroe Registration District No. 579
 (b) Township Madison Primary Registration District No. 5716 K Registered No. _____
 (c) City Madison, R. R. (d) Street No. _____ 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 Mary Morris Berkley
 (a) Residence, No. Madison R.R. 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 Female 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 James D. Berkley

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 19, 1875

| | | | | |
|--------|-------|--------|------|--|
| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day,hrs. ormin. |
| | 74 | 10 | 21 | |

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 10, 1940

22. I HEREBY CERTIFY, That I attended deceased from July 9, 1940 to July 10, 1940
 last seen alive on July 9, 1940. Death is said to have occurred on the date stated above, at 5:30 p.m.
 The principal cause of death and related causes of importance were as follows:
acute dilatation of the heart
tabes pneumonias of left lung
 Date of onset July 10
July 9

Other contributory causes of importance: 103

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

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? no
 If so, specify _____ (Signed) W. P. Turner, D.O. M.D.
 (Address) Madison, MO.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe County, Mo.

FATHER 13. NAME Woodrow Morris
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

MOTHER 15. MAIDEN NAME Neaiger
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

17. INFORMANT (ADDRESS) Mrs Ed Stuart

18. BURIAL PLACE Sunset Hill DATE July 12, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred A. Thompson
Madison, Mo.

20. FILED 7/11 19 40 W. P. Turner Local Registrar.

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.

RECORD WITH OBTAINING THIS IS A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 17-40-1432

Date Filed JUL 15 1940

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

Leed G. Johnson

Licensed Embalmer No. 1420

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22324

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 579

Primary Registration District No.

Registrar's No.

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

ROWENA MOORE

1. PLACE OF DEATH:

(a) County Mary Monroe
(b) City or town Madison
(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)

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) PRINT FULL NAME Mary Morris Berkeley

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 21 If less than one day..... hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name Columbia Yeager

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

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(Burial, cremation, or removal) (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 7/11/1940 (Date received local registrar) (b) Madison Mo (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10 year..... hour..... minute..... M.

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

Immediate cause of death.....

Due to.....

Due to.....

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

Major findings: Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 G. P. Turner (M.D. or other)..... Address Madison Mo Date signed.....

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REPUBLIC OF THE UNITED STATES OF AMERICA

FROM 1776 TO 1863

BY

W. H. CHAPMAN

NEW YORK

1863

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