

FEB 14 1941 8 30 Smith

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

1738

State File No. \_\_\_\_\_

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 9

10  
33  
4  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia

(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community 11 yrs.  
years, months or days

3. (a) PRINT FULL NAME WALTER W BERRY

3. (b) If veteran, name war No.

3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife AMANDA FREMING

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(Day) (Year)

7. Birth date of deceased 4 9 1865  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>9</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation RETIRED MERCHANT

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

MOTHER FATHER

12. Name BENJAMIN BERRY

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

14. Maiden name LIVONIA PEARCE

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

16. (a) Informant Mrs. ETTA BENEDICT

(b) Address Columbia Mo

17. (a) BURIAL (b) Date thereof 1-14-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rocky Fork Boone County

18. (a) Signature of funeral director Parker-Tenn. Co

(b) Address Columbia Mo

19. (a) 1/13/41 (b) Allie Selby  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Columbia  
(If outside city or town limits, write "RURAL")

(d) Street No. 207 Hickman  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 12 day  
year 1941 hour 11a minute 0 M.

21. I hereby certify that I attended the deceased from Jan 11 1941 to Jan 11 1941

that I last saw him live on Jan 11 1941

and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis  
Heart

Duration 2 days

Due to Gen Arterio Sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

23. Signature Stephen D Smith (Specify type of place) \_\_\_\_\_  
Address Columbia (b) Means of injury \_\_\_\_\_  
Date signed \_\_\_\_\_

83R

WFO  
G  
M

**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, fact should be so stated above.**

No. 2B  
2-21-40  
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STANDARD CERTIFICATE OF DEATH

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 73

Primary Registration District No. 3006

Registrar's No.

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbian  
(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)

3. (a) PRINT FULL NAME Walter W Berry

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

4. Sex m 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

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

8. AGE: Years Months Days If less than one day min.  
75 9 3

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

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

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

19. (a) 3/28/41 (b) Allie Selby  
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 12  
year 1941 hour minute M.

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.

Immediate cause of death paralysis

Throat Cerebral thrombosis

Due to uremia

Due to Arteriosclerosis

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

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

MOTHER FATHER

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