

FILED OCT 28 1942

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 31737

Registrar's No. 8608

Registration District No. 318

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... ST. LOUIS, MO.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution.....
ST LOUIS CHILDREN'S HOSP.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... 1 DAY
(Specify whether
 In this community..... NEVER
years, months or days)

3. (a) PRINT FULL NAME..... A. D. BERRY
 3. (b) If veteran, name war..... No
 3. (c) Social Security No..... CHILD

4. Sex..... MALE 5. Color or race..... WHITE 6. (a) Single, widowed, married, divorced..... CHILD
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased..... 1 21 42
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
8 23 hr. min.

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

10. Usual occupation..... CHILD

11. Industry or business.....

12. Name..... THOMAS BERRY

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

14. Maiden name..... CLETTA HENSON

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

16. (a) Informant..... M. W. KIMMEL
 (b) Address..... 500 SO. KINGSHIGHWAY

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

(c) Place: burial or cremation..... Campbell, Mo.

18. (a) Signature of funeral director..... Albert H. Hoppe Inc.
 (b) Address..... 4700 Washington Blvd.

19. (a) OCT 16 1942 (b) J. F. Beedeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... MISSOURI (b) County..... New Madrid
 (c) City or town..... GIDEON
(If outside city or town limits, write "RURAL")
 (d) Street No..... 6
(If rural, give location)
 (e) Citizen of foreign country?..... No (Yes or No)
 If yes, name country..... 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... 10 day..... 14
 year..... 42 hour..... 7 minute..... 28 P. M.

21. I hereby certify that I attended the deceased from..... 10-13
 1942, to..... 10-14, 1942
 that I last saw him alive on..... 10-14, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Malnutrition
Due to improper food
administration

Due to.....
 Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)
17713
158

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..... 000
 (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?
(Specify type of place)
 While at work?..... (e) Means of injury.....

23. Signature..... J. F. Beedeck (M. D. or other)
 Address..... J. F. Beedeck Date signed.....

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..... *G. W. Wilkinson*
Licensed Embalmer No..... *3575*
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.