

U.S. No. 2
DOM-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17317

FILED MAY 29 1944

Registration District No. 1944

Primary Registration District No. 5044

Registrar's No. 34

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

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Washington, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home of Frank Bahl 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Elizabeth Ellen Berry

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

4. Sex F 1. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife John Wesley Berry 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 14, 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Joseph C. Steel

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

14. Maiden name Garnette Ann Casteel

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

16. (a) Informant Mrs. Vernon J. Miller
(b) Address Port Smith, Ark. Rt 2

17. (a) Burial (b) Date thereof 4-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spring River Cem.

18. (a) Signature of funeral director W. D. Hoover
(b) Address Cassville, Mo.

19. (a) Apr 7-1944 (b) Grace Williams
(Date received local registrar) (Registrar's signature)

1077

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lawrence
(c) City or town Verona
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th
year 1944 hour 11 am minute _____ M.
21. I hereby certify that I attended the deceased from April 5th
1944, to April 5, 1944.
that I last saw her alive on April 5, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis - acute
Due to not known

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

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN 930
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 W. R. M. & Cline J (M.D. or other) D.O.
Address Cassville, Mo. Date signed 4/14/44

RECEIVED

District Health Officer No. 8,

District File Number 544-631

Date Filed MAY 24 1944

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 W. C. Koon

Licensed Embalmer No. 4359

P. O. Address Cassville, 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, fact should be so stated above.