

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21456

State File No. _____

FILED JUL 13 1944

Registration District No. 10

Primary Registration District No. 5364

Registrar's No. 64

1. PLACE OF DEATH:
(a) County Daviess
(b) City or town Rural Liberty Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5 Miles N. W. Gallatin, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community 4 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Daviess 31
(c) City or town Rural Liberty Township 0
(If outside city or town limits, write "RURAL")
(d) Street No. 5 Miles N. W. Gallatin, 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Thomas Berry
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Cora Alice Oxford
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased March 2 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 3 26 hr. min.

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

10. Usual occupation Farmer
11. Industry or business Own Farm

MOTHER FATHER { 12. Name Killian Berry
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Harriett (Unknown)
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Thomas Berry
(b) Address Gallatin, Mo.

17. (a) Burial (b) Date thereof 6-30-1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Zion Cemetery

18. (a) Signature of funeral director Hope Funeral Home
(b) Address Gallatin, Mo.

19. (a) 7-5-1944 (b) L. O. Dickerson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
year 1944 hour 9 minute 50 A. M.
21. I hereby certify that I attended the deceased from June 20
1944 to June 27 1944
that I last saw him alive on June 27 1944
and that death occurred on the date and hour stated above.

Immediate cause of death:
Uremic poisoning
+ probable myocardial infarction
due to
hypertrophy of prostate gland
due to
pathology of urinary bladder
Duration
Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations: 137a
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?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature M. B. Bailey MD
Address Gallatin, Mo. Date signed 7/5-44

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

3100

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 *L. O. Richesson*

Licensed Embalmer No. *3307*

P. O. Address *Fall River 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.