

S. No. M-542 5-17-39 I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31027

FILED OCT 11 1945

State File No.

Registration District No. 224

Primary Registration District No. 3046

Registrar's No. 3

1. PLACE OF DEATH:
 (a) County Monteale
 (b) City or town California
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Katharine Sanitarium
 (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 Monteale (b) County Monteale
 (c) City or town California
 (If outside city or town limits, write "RURAL.")
 (d) Street No. 1
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Daisy Berkeley
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 9 day 14
 year 1945 hour 4 minute 0 M.
 21. I hereby certify that I attended the deceased from June 27, 1945 to Sept 14, 1945
 that I last saw her alive on Sept 14, 1945
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 1
 6. (b) Name of husband or wife Ellis Berkeley 6. (c) Age of husband or wife if alive 49 years
 7. Birth date of deceased 4 18 89
 (Month) (Day) (Year)

Immediate cause of death Carcinoma of uterus (and all pelvic and abdominal organs)
 Due to.....
 Due to.....
 Other conditions General Dropsy
 (Include pregnancy within 3 months of death)

8. AGE: Years 56 Months 10 Days..... If less than one day hr. min.
 9. Birthplace Morgan Co Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Home wife

Major findings: Of operations (Operation about 1 yr ago)
 Of autopsy none
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 12. Name Ellis Weauer
 13. Birthplace Law County Ohio
 (City, town, or county) (State or foreign country)
 14. Maiden name Anna J. Hill
 15. Birthplace Jackson Co Mo
 (City, town, or county) (State or foreign country)
 16. (a) Informant J. J. Weauer
 (b) Address Barnett, MO
 17. (a) Burial (b) Date thereof 9-16-1945
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation.....
 18. (a) Signature of funeral director Phillipo Lewis
 (b) Address Bidon Mo
 19. (a) 9-19-45 (b) H.R. Poppey M.D.
 (Date received local registrar) (Registrar's signature)

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?
 (Specify type of place) (e) Means of injury.....
 While at work.....
 23. Signature L. D. Latham (M. D. or dentist)
 Address California Mo Date signed 9-21-45

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

1027

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 10-10-45

OCT 15 1945

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 Louis D. Phillips
Licensed Embalmer No. 3669
P. O. Address Bevan

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 017
Registrar's No. 3

Registration District No. 224 Primary Registration District No. 3046

1. PLACE OF DEATH:

(a) County Moniteau
(b) City or town California
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Daisy Berkeley

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive 53 years

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

8. AGE: Years 56 Months _____ Days _____
if less than one day _____ 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 _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I first saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
(Immediate cause of death) _____

Duration _____

Due to _____

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____
(Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

31027