No. 2
1-2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 17 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36793

Registration District No. 21 Primary Registration District No. 6-07-6 5179 Registrar's No. 26-14

1. PLACE OF DEATH:

(a) County CAMDEN

(b) City or town OSAGE BEACH
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community x 13 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County CAMDEN 15

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

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME LESLIE W. BERRY

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex MALE 0

5. Color or race WHITE

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

6. (b) Name of husband or wife CHRISTENA S.

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased JUNE (Month) 22 (Day) 1890 (Year)

8. AGE:

Years	Months	Days	If less than one day
55	4	20	hr. min.

9. Birthplace BRENTWOOD (City, town, or county) MO. 0 (State or foreign country)

10. Usual occupation REAL ESTATE

11. Industry or business " "

MOTHER FATHER

12. Name JOHN MARSHALL BERRY

13. Birthplace ST. LOUIS COUNTY 0 (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name ANNIE S. BERRY

15. Birthplace ST. LOUIS COUNTY 17 (City, town, or county) (State or foreign country)

16. (a) Informant x Mrs. Leslie W. Berry

(b) Address Osage Beach Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine, St. Louis

18. (a) Signature of funeral director Jay B. Smith

(b) Address 7456 Manchester Ave. Maplewood, Mo.

19. (a) 11-16-45 (Date received local registrar) (b) E. D. Barnard M.D. (Registrar's signature)

15 10 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 10 TH year 1945 hour 11 minute 50 P.M.

21. I hereby certify that I attended the deceased from MAY 11, 1945, to NOV 10, 1945, that I last saw him alive on NOV 10 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death PNEUMONIA.	2 days
Due to METASTIC SARCOMA OF LUNGS	4 mo
Due to OSTEO SARCOMATA OF ILEI & LUMBAR VERTEBRAE	6 mo
Other conditions (Include pregnancy within 3 months of death) H 7A	

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? (Specify type of place)

While at work (e) Means of injury

23. Signature L. Dale Atterbery DO (M.D. or other)

Address Camdenton Mo. Date signed 11-11-45

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 3457

....., Registered Apprentice No.....,

working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3457

P. O. Address 7456 Manchester

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
5M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 2614

1. PLACE OF DEATH:
(a) County Saunders
(b) City or town
(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 years, months or days)
In this community

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 Leslie 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 M

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years

7. Birth date of deceased June 22 1878
(Month) (Day) (Year)

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 24
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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)
(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 (M. D. or other)
Address Date signed

36793