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**FILED** DEC 12 1945 **STANDARD CERTIFICATE OF DEATH**

38121

State File No. \_\_\_\_\_

Registration District No. 272

Primary Registration District No. 5907

Registrar's No. 17

**1. PLACE OF DEATH**

(a) County Pemiscot Mo  
(b) City or town Rural  
(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 3 yrs years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Pemiscot  
(c) City or town Rural  
(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**

Mary Elizabeth Berry

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

4. Female 5. Color or race W 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Charley Berry 6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased March 15 1872 (Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Charles Berry

(b) Address Portageville, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-45 (Month) (Day) (Year)

(c) Place: burial or cremation Portageville

18. (a) Signature of funeral director Dr. H. H. Turner

(b) Address Portageville, Mo

19. (a) 11-29 (Date received local registrar) (b) S. J. Williams (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov day 13 year 1945 hour 1 minute \_\_\_\_\_ A.M.  
21. I hereby certify that I attended the deceased from July 15 1945 to \_\_\_\_\_ 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death stroke - appetitic  
Due to Hypertension -

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 J. H. Chapman (M. D. or other) \_\_\_\_\_  
Address Stella, Mo Date signed 11-27-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

11-45-213

**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

*Leonard John Vargo*

Licensed Embalmer No.

4336

P. O. Address

*Portagenille, 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.**

Registration District No. 272

Primary Registration District No. (5907)

1. PLACE OF DEATH:  
 (a) County Pemiscot  
 (b) City or town Cooter-Cooter Pub. Rural  
(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)

3. (a) PRINT FULL NAME Mary E. Berry  
 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 \_\_\_\_\_  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_  
 7. Birth date of deceased mar 15 1915  
(Month) (Day) (Year)

8. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_  
hr. 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) L. J. Williams  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ 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)

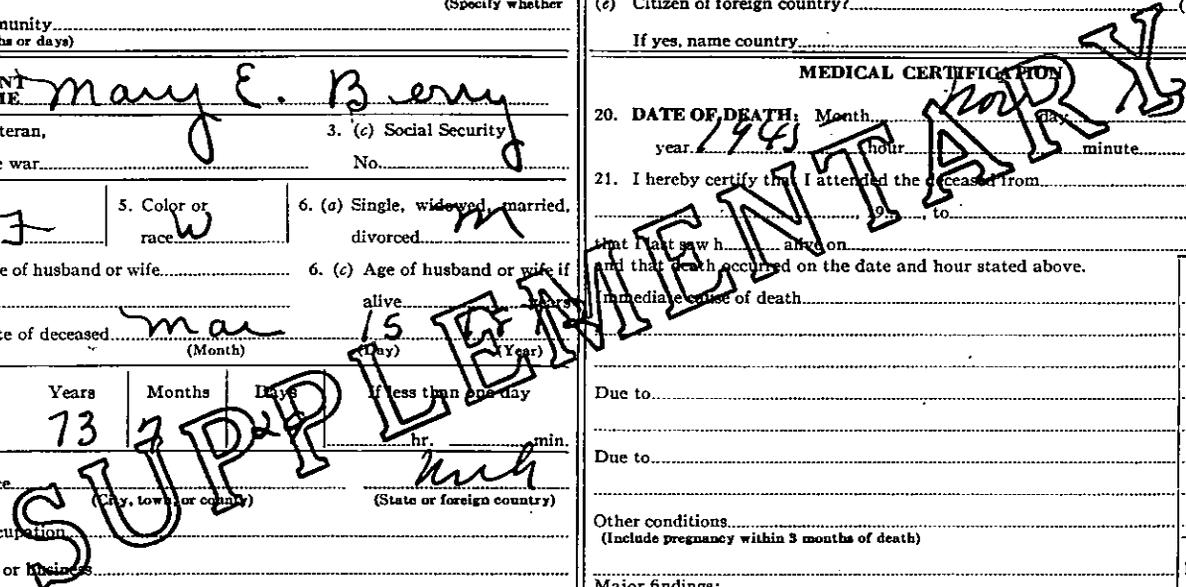
PHYSICIAN

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

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



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