

FILED DEC 29 1945

Registration District No. **383**

Primary Registration District No. **5655**

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mt. Vernon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 152 days
(Specify whether years, months or days)

In this community 152 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Douglas

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

(d) Street No. 24
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Nellie Irene Berent

3. (b) If veteran, name war no

3. (c) Social Security No. unknown

4. Sex female **5. Color or race** white

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

6. (b) Name of husband or wife William John Berent

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

7. Birth date of deceased Aug. 22 1916
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>29</u>	<u>2</u>	<u>11</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Worley A. Herron

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

14. Maiden name Orpha K. Brown

15. Birthplace Mt. Vernon Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk Mo. State Sanatorium

(b) Address _____

17. (a) Removal **(b) Date thereof** Nov 3 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sullivan, Mo

18. (a) Signature of funeral director Max S. Kowitz

(b) Address Mt. Vernon, Mo

19. (a) 12-8-45 **(b)** Dr. Helbert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 2d
year 1945 hour 1:45 minute _____ P. M.

21. I hereby certify that I attended the deceased from June 4th 1945 to Nov. 2d 1945;
that I last saw her alive on Nov. 2d 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death. Spontaneous pneumothorax abt 10 days

Due to Far Advanced Pulmonary Tbc. Abt. 3 yrs.

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy 13h

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? _____

23. Signature P. A. Braxler M.D. (M.D. or other)

Address Mt. Vernon, Mo **Date signed** 12-2-45

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number: 1245-1189

Date Filed 12-18-45

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed Max L. Fossitt

Licensed Embalmer No. 4252

P. O. Address Mt Vernon, 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.