

No. 2
5-43
1-17-39
X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6210**

FILED MAR 7 1946
Registration District No. **161**

Primary Registration District No. **5594**

Registrar's No. **11**

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

1. PLACE OF DEATH:
(a) County **JEFFERSON**
(b) City or town **RURAL - MERA MECHM**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ST. JOSEPH'S HILL INFIRMARY**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 DAYS**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Baltimore**
(c) City or town **Rural - Palma**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **JACOB A. BERRY**
(b) If veteran, name war **NONE**
(c) Social Security No. **NONE**
4. Sex **M** Color or race **W**
5. (a) Single, widowed, married, divorced **WIDOWED**
(b) Name of husband or wife **EMMA McMINN**
(c) Age of husband or wife if alive **1 YEAR** years
6. Birth date of deceased **1.1.1869**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **February** day **17** year **1946** hour **11** minutes **20** A.M.
21. I hereby certify that I attended the deceased from **February 2 12 1946** to **February 2 12 1946**
that I last saw him alive on **2 12 1946** and that death occurred on the date and hour stated above.
Immediate cause of death **CORONARY Occlusion** Duration **N**

8. AGE: Years **76** Months **4** Days **13** If less than one day hr. min.
9. Birthplace **Mable Hill MO**
(City, town, or county) (State or foreign country)
10. Usual occupation **Merchant**
11. Industry or business **Store**

Due to **ARTERIO-SCLEROTIC-CARDIO-VASCULAR-DISEASE**
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy **93d**

MOTHER FATHER
12. Name **William Berry**
13. Birthplace **Madison town MO**
(City, town or county) (State or foreign country)
14. Maiden name **Cynthia Barber**
15. Birthplace **Mable Hill MO**
(City, town, or county) (State or foreign country)
16. (a) Informant **Protus Rob D.S.**
(b) Address **St. Joseph's Hill Infirmary**
17. (a) **BURIAL** (b) Date thereof **2-19-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **GREEN ALLEN, MO.**
18. (a) Signature of funeral director **BAKER FUNERAL HOME**
(b) Address **LUTESVILLE, MO.**
19. (a) **February 26 1946** (b) **Mrs. J. H. Nuekels**
(Date received by 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? _____
While at work: (Specify type of place) _____
(e) Means of injury _____
23. Signature **J. H. Nuekels** (M. D. or other) _____
Address **3155 NO. VANDEVENTER** Date signed **2/17/46**

PHYSICIAN
Underline the cause to which death should be charged statistically.

14X

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 3-6-46

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 J E Graham

Licensed Embalmer No. 4010

P. O. Address Lutesville, 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.