

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **23648**

FILED AUG 16 1948

Registration District No. **231**Primary Registration District No. **4346**Registrar's No. **19**

1. PLACE OF DEATH:

(a) County **Montgomery**
(b) City or town **Montgomery**
(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 **4 Months** (Specify whether
In this community **4 Months** years, months or days)

3. (a) PRINT
FULL NAME **Dona Jane Berry**

3. (b) If veteran, name war **F /** 3. (c) Social Security No. **No.**

4. Sex **F /** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W 2**
6. (b) Name of husband or wife **Richard Berry** 6. (c) Age of husband or wife if alive **Deceased**
7. Birth date of deceased **Feb 1 st 1874** (Month) (Day) (Year)

8. AGE: Years **74** Months **2** Days **27** If less than one day hr. min.

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

10. Usual occupation **Home**

11. Industry or business

MOTHER FATHER { 12. Name **Charles Weeks**
13. Birthplace **Va** (City, town, or county) (State or foreign country)
14. Maiden name **Mary E. Clement**
15. Birthplace **Callaway Co Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **George Garrett**
(b) Address **Montgomery City Mo**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **8 4-29-48** (Month) (Day) (Year)
(c) Place: burial or cremation **Antioch Cemetery**

18. (a) Signature of funeral director **C. W. Hopkins**
(b) Address **Montgomery City Mo**
19. (a) **4-30-48** (Date received local registrar) (b) **Union Springs** (Registrar's signature) **1948**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Callaway** **14**
(c) City or town **Williamsburg** (If outside city or town limits, write "RURAL") **2**
(d) Street No. **1** (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **28** year **1948** hour **8** minute **1** A.M.
21. I hereby certify that I attended the deceased from **May 2** 19 **46** to **April 28** 19 **48**
that I last saw him alive on **April 28** 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Massive Cerebral Hemorrhage** Duration **3 hrs.**
Due to **Intestinal Neoplasia** **1 1/2 yrs.**

Due to **131B**
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **131B**
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?
While at work? (Specify type of place) (c) Means of injury **0**

23. Signature **James O. Helm** (M. D. or other) **1948**
Address **New Florence Mo** Date signed **4-29-48**

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed AUG 13 1948

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, xx on the 28
day of April 1948, Registered Apprentice No. _____
working under my personal supervision.

Signed C. V. Hopkins

Licensed Embalmer No. 1487

P. O. Address Montgomery City Mo.

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

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