

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4776

645

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Jackson		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 40 Years	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		d. STREET ADDRESS (If rural, give location) 4515 Wornall Rd.
d. FULL NAME OF HOSPITAL OR INSTITUTION 4515 Wornall Rd.					

3. NAME OF DECEASED (Type or Print) a. (First) Nelle b. (Middle) Maree c. (Last) Berkley			4. DATE OF DEATH (Month) (Day) (Year) 2-9-49		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Oct. 25, 1895	9. AGE (in years last birthday) 53	IF UNDER 1 YEAR Months 3 Days 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Keeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME William Berkley		13b. MOTHER'S MAIDEN NAME Lucretia Maffat		14. NAME OF HUSBAND OR WIFE No	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 495-09-2048	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Hugh G. Berkley (Sister-in-law)			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION <u>a.k.</u> DIRECTLY LEADING TO DEATH* (a) Congenital Cystic Disease of Lungs.			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			759.0

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 8/21, 1948, to 2/9, 1949, that I last saw the deceased alive on 2/8, 1949, and that death occurred at 12:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE Edson C. Carrier (Degree or title) M.D.		23b. ADDRESS 242 Plaza Med Bldg.		23c. DATE SIGNED 2/11/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-12-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Belton, Mo.		
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DATE REC'D BY LOCAL REG. 2-12-49	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE 3235 GILLHAM PIA ZA			
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Courcier
Kearney - Poole
Kearney
Playa med. Bldg.

1-5-6

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Robert H Reed

Licensed Embalmer No. 3745

P. O. Address 1100 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.