

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

13580

State File No. ....

No. 300  
10.48

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

520

**FILED MAY 5 1950**

BIRTH NO. _____		REG. DIST. NO. <u>164</u>		PRIMARY REG. DIST. NO. <u>4258</u>		Registrar's No. <u>23</u>	
1. PLACE OF DEATH a. COUNTY <u>Knox</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Knox</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Edina, Mo</u>		c. LENGTH OF STAY (in this place) <u>6 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>		<u>05 30</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Gibson Hospital &amp; Clinice</u>				d. STREET ADDRESS (If rural, give location) <u>7 Miles Southwest of Edina,</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Walter</u>			b. (Middle) <u>Gano</u>		c. (Last) <u>Berry</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 24 1950</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 18 1861</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>North Middletown, Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Joel S. Berry</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Butler Berry</u>		14. NAME OF HUSBAND OR WIFE <u>Miss Ada Lena Campbell</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Maurine B. Davis</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral accident</u>			
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerotic heart disease</u>			
				DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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 <u>4/19</u> , 19 <u>50</u> , to <u>4/24</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4-24</u> , 19 <u>50</u> , and that death occurred at <u>3:30Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>[Address]</u>		23c. DATE SIGNED <u>4/25/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April 26</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		24d. LOCATION (City, town, or county) (State) <u>Knox county, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>4-25-50</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		FURNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Edina, Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

MAY 1 1950

District Health Officer No. \_\_\_\_\_

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

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.

Signed Mrs. J. W. Hudson \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2972 \_\_\_\_\_

P. O. Address Edina, 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.