

0.300  
0.48

FILED SEP 6 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27754

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 282

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sedalia</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sedalia, 2804</b>	
c. LENGTH OF STAY (in this place) <b>6 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>1211 East Broadway</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Bothwell Hospital</b>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>MARY</b>	b. (Middle) <b>J.</b>	c. (Last) <b>BERKEY</b>	(Month) <b>Aug.</b>	(Day) <b>26,</b>	(Year) <b>1950</b>

5. SEX <b>Fe</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 15, 1878</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months	IF UNDER 1 MRS. Hours	Min.
------------------	-------------------------------	---	---------------------------------------	---	------------------------	-----------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Aikensville, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
---	--	---	--

13a. FATHER'S NAME <b>Alfred B. Aiken</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Hodges</b>	14. NAME OF HUSBAND OR WIFE <b>J. W. Berkey</b>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>O. J. Aiken, 1314 E. B'way, Sedalia</b>	ADDRESS
---	-----------------------------------	---	---------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocarditis, Chronic</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>443X</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>hypertension</b>		
	DUE TO (c) <b>Cerebral haemorrhage</b>		
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 checked="" 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 Jan 1950 to Aug 26, 1950, that I last saw the deceased alive on Aug 26, 1950, and that death occurred at 4:30 A.M. m., from the causes and on the date stated above.

23a. SIGNATURE <b>Chas. Linder Hauptfeld M.D.</b>	(Degree or title)	23b. ADDRESS <b>Sedalia, Mo.</b>	23c. DATE SIGNED <b>8-27-50</b>
--	-------------------	-------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Aug 29, 1950</b>	24c. NAME OF CEMETERY OR CREMATORY: <b>Aikensville</b>	24d. LOCATION (City, town, or county) (State) <b>Aikensville, Mo</b>
--	----------------------------------	---	---

DATE REC'D BY LOCAL REG. <b>8/29-1950</b>	REGISTRAR'S SIGNATURE <b>A. J. Campbell M.D. Deputy</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>D. W. Deakart</b>	ADDRESS <b>Sedalia, Mo</b>
--	--	--	-------------------------------

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

RECEIVED 9-5  
DISTRICT HEALTH OFFICE No. 3  
District File Number \_\_\_\_\_  
Date Filed: 9-5-50

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 \_\_\_\_\_

Licensed Embalmer No. 3470

P. O. Address Sedalia, 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.