

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **20194**
Registrar's No. **5262**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		6. STREET ADDRESS (If rural, give location) 4836 Maffitt 2069 D	
3. NAME OF DECEASED (Type or Print) Carrie Berry		4. DATE OF DEATH (Month) (Day) (Year) 6 11 54	
5. SEX Female		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
6. COLOR OR RACE Negro		8. DATE OF BIRTH 12-16-1891	
9. AGE (In years last birthday) 62		10. UNDER 1 YEAR (Months) (Days) (Hours) (Min.) 5 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Unemployed	
11. BIRTHPLACE (City and State or Foreign Country) Mariana Arkansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Dave Wright		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Louise Carey		ADDRESS 4836 Maffitt Ave.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease Undetermined Abdominal Mass 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 Congestive Failure Right Pleural Effusion	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 4200			
22. I hereby certify that I attended the deceased from 6-8 , 19 54 , to 6-11 , 19 54 , that I last saw the deceased alive on 6-11 , 19 54 , and that death occurred at 8:05A m., from the causes and on the date stated above.			
23a. SIGNATURE E. B. Williams		(Degree or title) M.D.	
23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 6-11-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-14-54	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis; Mo.	
DATE REC'D BY LOCAL REG. JUN 14 1954		REGISTRAR'S SIGNATURE Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Atkins Bros. Und. Co.		ADDRESS 3644 Finney	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10, 48

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.....
Signature of Student Embalmer

Signed *John R Cunningham*

Licensed Embalmer No....4476

P. O. Address...4700 Hammett

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fail to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**