

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32675**

FILED NOV 8 1955

BIRTH NO. _____ REG. DIST. NO. **99** PRIMARY REG. DIST. NO. **5376** Registrar's No. **49**

1. PLACE OF DEATH a. COUNTY DeKalb b. CITY (If outside corporate limits, write RURAL and give township) OR Pattonsburg c. LENGTH OF STAY (In this place) Life		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY DeKalb c. CITY (If outside corporate limits, write RURAL and give township) OR Pattonsburg d. STREET ADDRESS (If rural, give location) 320	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Home of Foster Berry			

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) Clifton c. (Last) Berry			4. DATE OF DEATH (Month) 10 (Day) 28 (Year) 55		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 12-24-1869		9. AGE (In years last birthday) 86 If under 1 year: Months _____ Days _____ If under 12 hrs: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Mo.	
13a. FATHER'S NAME Joseph Berry				13b. MOTHER'S MAIDEN NAME Pauline Hullett	
14. NAME OF HUSBAND OR WIFE none				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. XXXXXXXXXX		17. INFORMANT'S SIGNATURE OR NAME Foster Berry	
				ADDRESS Pattonsburg Mo.	

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 DIRECTLY LEADING TO DEATH* (a) Chronic Endocarditis ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 4214 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 7	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES ☐ NO ☐	
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)		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May 1948, to 10/28, 1955, that I last saw the deceased alive on 10/28, 1955, and that death occurred at 9:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Typed or title) Wm. Harold Foster		23b. ADDRESS Maysville Mo.		23c. DATE SIGNED 10/29/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-1-55	24c. NAME OF CEMETERY OR CREMATORY Berlin		24d. LOCATION (City, town, or county) (State) Berlin Mo.	

DATE REC'D BY LOCAL REG. 11-4-55	REGISTRAR'S SIGNATURE R. M. Davidson	25. FUNERAL DIRECTOR'S SIGNATURE John Brown	ADDRESS Maysville Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Signed.....
Student Embalmer -

Signed

Student Embalmer No.....

Licensed Embalmer No. 3933

P. O. Address Maysville 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.