Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-036267
STATE FILE NUMBER

FILED NOV 14 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5073

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): KANSAS City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 919 OAK STREET — Length of stay in 1b: 18 YEARS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 919 OAK STREET — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: CHARLES Middle: E. Last: BERRY
4. DATE OF DEATH: Month: October Day: 26 Year: 1958
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Nov 1881
9. AGE (In years last birthday): 76 — 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): RETIRED DEPUTY SHERIFF
10b. KIND OF BUSINESS OR INDUSTRY: CLAY COUNTY MISSOURI
11. BIRTHPLACE (City and state or country): NEAR DeKalb, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: William BERRY
13b. MOTHER'S MAIDEN NAME: ANNA
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 489-22-7166
17. INFORMANT: Miss ADDIE BERRY — Address: 4520 OLIVE STREET KANSAS CITY, MISSOURI

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4201
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Hugh O A Owens (Degree or title) Coroner — 22b. ADDRESS: 1034 Rialto Bldg — 22c. DATE SIGNED: 10-27-58
23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE: Oct 29 1958 — 23c. NAME OF CEMETERY ~~OR CREMATORY~~: GRACELAND CEMETERY — 23d. LOCATION (City, town, or county) (State): WESTON MISSOURI
24. FUNERAL DIRECTOR: D.W. NEWCOMER'S SONS — ADDRESS: 1331 BRUSH CREEK KANSAS City, Mo
25. DATE RECD. BY LOCAL REG.: 10-28-58
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh H. Owens

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 Norman W. Thorson

Licensed Embalmer No. 4889

P. O. Address T. C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.