

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 4 1960

STATE FILE NUMBER
-59-046918

Registration District No. 296 Primary Registration District No. 6018 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> <i>Making River Loop</i>		Length of stay in 1b <u>18 yrs.</u>	c. CITY OR TOWN <u>Excelsior Springs</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RR#2</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RR#2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Charles Berry</u>			4. DATE OF DEATH Month Day Year <u>December 18, 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1878</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>81</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Toluca, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Berry</u>		13b. MOTHER'S MAIDEN NAME <u>Mary O'Riely</u>		14. NAME OF HUSBAND OR WIFE <u>Birdie Grove</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs. Joseph Berry. RR#2. Excelsior Springs Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 wks.</u> <u>4 years</u>
IMMEDIATE CAUSE (a)	<u>Tuberculosis (Bronchial)</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Uremia</u>	
DUE TO (b)	<u>Carcinoma of Prostate + Bladder</u>	DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 10/11/55 to 12-18 and last saw her alive on 12-14-59
Death occurred at 11 35 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Agnes B. Pohlman M.D.</u>	22b. ADDRESS <u>116 South St. Mo. Excelsior Springs</u>	22c. DATE SIGNED <u>12-19-59</u>
23a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-20-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ann</u>
23d. LOCATION (City, town, or county) <u>Toluca, Illinois</u>		23e. LOCAL REG. NO. <u>12-30-59</u>

24. FUNERAL DIRECTOR ADDRESS <u>Prichard Funeral Home, Inc. Excelsior Springs, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>12-30-59</u>	26. REGISTRAR'S SIGNATURE <u>Helen J. Larkin</u>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

VS JAN 18 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Ralph Van Landingham

Licensed Embalmer No. 4009

Quincy Springs

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.