

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034635

FILED VS. SEP 20 1960

149

Primary Registration District No. 1002

Registrar's No. 4504

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 20 yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1409 E. 9th. St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MRS. NORA BERK				4. DATE OF DEATH Month Day Year Sept., 2, 1960				
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-15-1886	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Springfield, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Henderson Huff			13b. MOTHER'S MAIDEN NAME Harriet Weatherman			14. NAME OF HUSBAND OR WIFE Harry Berk		
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. 488-16-0317		17. INFORMANT Address Mr. Harry Berk---1409 E. 9th. St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia							INTERVAL BETWEEN ONSET AND DEATH 2 wks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic bronchial asthma & emphysema							over 6 yrs	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 10-27-55 to 9-2-60 and last saw her ^{him} alive on 9-1-60 Death occurred at 6:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Wilson H. Miller, M.D.				22b. ADDRESS 4620 Ind. Ave. Kans. City, Mo.			22c. DATE SIGNED 9-2-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-6-60	23c. NAME OF CEMETERY OR CREMATORY HAZELWOOD CEM.			23d. LOCATION (City, town, or county) (State) Springfield, Missouri		
24. FUNERAL DIRECTOR Melody-McGilley-Eylar F.H.-1800 E. Linwood				25. DATE RECD. BY LOCAL REG. 9.3.60		26. REGISTRAR'S SIGNATURE H-L Dwyer		

DOCUMENT

BY AFFIDAVIT OF WILSON H. MILLER, M.D. MEDICAL CERTIFICATION

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2015

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Dr. Hill
4620 D

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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 Robert F. Fuller

Licensed Embalmer No. 4818

P. O. Address KC Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.