

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042367

VS DEC 14 1960

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 571

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 19 yrs.	c. CITY OR TOWN Rural Jackson County		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1012 Turner Rd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MR. ROY MARKWELL BERRIAN			4. DATE OF DEATH Nov ember 30, 1960		
5. SEX Male	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 Aug. 31, 1889	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Columbus, Ill.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Wm. A. Berrian		13b. MOTHER'S MAIDEN NAME Nancy Judy		14. NAME OF HUSBAND OR WIFE Lenora Berrian	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.#1		16. SOCIAL SECURITY NO. 509-14-5687		17. INFORMANT Mrs. Lenora Berrian Address Jackson Co., Mo.	
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
IMMEDIATE CAUSE (a) Cardiac arrest					instant
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease					unknown
DUE TO (c) Generalized arteriosclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Ankylosing spondylitis				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 Month, Day, Year a.m. p.m.					
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 1959 , to 1960 and last saw him alive on 11-30-60 Death occurred at p m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Ink or blue ink) Carl B. Bachman MD			22b. ADDRESS Indep., Mo		22c. DATE SIGNED 12-2-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE Dec. 3, 1960	23c. NAME OF CEMETERY OR CREMATORY Oak Ridge Memory Garden		23d. LOCATION (City, town, or county) (State) Indep., Mo.	
24. FUNERAL DIRECTOR OTT & MITHCELL, Indep., Mo.		25. DATE RECD. BY LOCAL REG. 12-3-60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

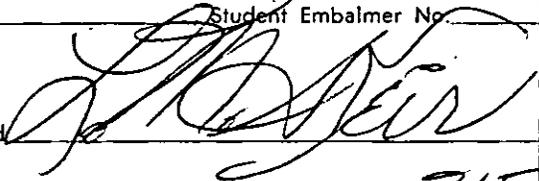
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 315

P. O. Address _____

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