ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-033864
STATE FILE NUMBER

AMENDED

Registration District No. 291 Primary Registration District No. Registrar's No. 58

FILED SEP 21 1961

1. PLACE OF DEATH
a. COUNTY PUTNAM
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RURAL- UNION. TWP
Length of stay in 1b: 1 DAY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION UNIONVILLE
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY PUTNAM
c. CITY OR TOWN UNIONVILLE
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle KENNETH Last BERRY

4. DATE OF DEATH: Month Sept Day 11 Year 61

5. SEX: M

6. COLOR OR RACE: W

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 6-24-03

9. AGE (last birthday): 58
IF UNDER 1 YEAR: Months 2 Days 17
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BULK TANK GAS

10b. KIND OF BUSINESS OR INDUSTRY: OWNER and OPERATOR

11. BIRTHPLACE (City and state or country): PUTNAM CO MO

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: JOHN L. BERRY

13b. MOTHER'S MAIDEN NAME: DELLA MAPLES

14. NAME OF HUSBAND OR WIFE: PAULINE BERRY

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.: 487-01-4394

17. INFORMANT: PAULINE BERRY Address: UNIONVILLE MO

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: 10 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis & hypertension — years
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 Sept 11-61 to Sept 11 61 and last saw him alive on Sept 11-61
Death occurred at 6:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Chas L Goddard

22b. ADDRESS: Unionville Mo

22c. DATE SIGNED: 9-12-61

23a. BURIAL, CREMATION, REMOVAL (Specify): B

23b. DATE: 9-13-61

23c. NAME OF CEMETERY OR CREMATORY: UNIONVILLE CEM.

23d. LOCATION (City, town, or county): UNIONVILLE (State): MO

24. FUNERAL DIRECTOR: O. HUSTED & SON ADDRESS: UNIONVILLE MO

25. DATE RECD. BY LOCAL REG.: 9-12-61

26. REGISTRAR'S SIGNATURE: Maxwell Durbin

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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 Murl C. Husted

Licensed Embalmer No. 3304

P. O. Address Amonville Ar

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.