

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043204

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 163 Primary Registration District No. 55-96 Registrar's No. 68

FILED NOV 19 1962

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>JEFFERSON</u>		a. STATE <u>Mo.</u>	b. COUNTY <u>ST. LOUIS</u>
b. CITY (if outside corporate limits, give TOWNSHIP) only OR TOWN <u>VINELAND (CE VALLE)</u>		c. CITY OR TOWN <u>AFTON</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Length of stay in lb <u>1 YR.</u>		d. STREET ADDRESS (if outside, give location) <u>7208 WATERFORD DR.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>FLORENCE * BERRY</u>			4. DATE OF DEATH Month Day Year <u>Nov. 15 1962</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*</u>	9. AGE (last birthday) <u>90</u>
11a. FATHER'S NAME <u>WILLIAM TIMBY</u>		11b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE <u>WILLIAM BERRY</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 <u>WINIFERD KNORR, VINELAND 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
IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u>			<u>4 days</u>
DUE TO (b) <u>arteriosclerosis</u>			<u>year</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 <u>Nov. 14, 1962</u> to <u>Nov. 15, 1962</u> and last saw her ^{her} _{him} alive on <u>Nov. 15, 1962</u> Death occurred at <u>8:40 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Harold E. Donnell M.D.</u>		22b. ADDRESS <u>De Soto, Mo.</u>	22c. DATE SIGNED <u>11-15-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov. 17/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CITY</u>	23d. LOCATION (City, town, or county) (State) <u>De Soto Mo.</u>
24. FUNERAL DIRECTOR <u>DIETRICH F. HOME</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 16-1962</u>	26. REGISTRAR'S SIGNATURE <u>Marie Harris</u>

DEC 11 1962

STATE OF MISSISSIPPI

Permit issued 11-16-62. M. B.

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 Donnell B. DeLoach

Licensed Embalmer No. 4104

P. O. Address DeLoach, 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.