

AUG 27 1935

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

27132

File No. 10

Registered No. 1105

1. PLACE OF DEATH

72 County New Madrid Registration District No. 55
Township Madison Primary Registration District No. 4033
2 City Osition (No. _____) St. _____ Ward _____

2. FULL NAME

Wifford Berry
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-12-1934

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
1 1 16

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Osition Mo.
(STATE OR COUNTRY)

13. NAME Emerson Berry

14. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY)

15. MAIDEN NAME Dollie Jordan

16. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY)

17. INFORMANT Emerson Berry
(ADDRESS) Osition Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Joseph DATE 8-3 1935

19. UNDERTAKER W. V. Weentemeyer
(ADDRESS) Osition Mo

20. FILED Aug 27 1935 M. V. Mumma
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 1 1935

22. I HEREBY CERTIFY, That I attended deceased from

7-28, 1935, to 8-1, 1935

I last saw him alive on 8-1, 1935. Death is said

to have occurred on the date stated above, at 11 P. m.

The principal cause of death and related causes of importance were as follows:

Innocentia
Embryonic Paratyphoid
and
Congestion of Lungs

Date of onset

Other contributory causes of importance:
Cholera Infantum

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external cause (violence), fill in also the following:

Accident, suicide, or homicide _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Geo. F. Johnson, M. D.

(Address) Osition Mo.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

11. 11. 1954

12. 11. 1954

13. 11. 1954

14. 11. 1954

15. 11. 1954

16. 11. 1954

17. 11. 1954

18. 11. 1954

19. 11. 1954

20. 11. 1954

21. 11. 1954

22. 11. 1954

23. 11. 1954

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE FILED WITH
THIS SUPPLEMENTARY,

1. PLACE OF DEATH

County New Madrid Registration District No. 58-
Township _____ Primary Registration District No. 4033
City Osceola (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S.
(Write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 1, 1935

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 1 19

Date of onset _____

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

Myocarditis
Infantile paralysis and
congestion of lungs
acute anterior poliomyelitis

Other contributory causes of importance:
Constriction of lungs
caused by coed

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19____

19. UNDERTAKER (ADDRESS) _____

20. FILED Aug 10, 1935 M. V. Mamma
Registrar.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Geo. Fulkerson, M. D.
(Address) Osceola Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

SEP 4 1936

1936

S-27132