V. S. No. 2
30M—8-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5454

Registration District No. 10 Primary Registration District No. 5037 Registrar's No. 25

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Salt River Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Audrain
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME CHARLES THOMPSON BERREY
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Feb. 14 1868 (Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 1 If less than one day ___hr. ___min.

9. Birthplace Audrain Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business
FATHER 12. Name Austin Berrey
13. Birthplace Virginia (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Martha Sossbuffer
15. Birthplace Ky. (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Joe Smith
(b) Address Mexico Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16 1945 (Month) (Day) (Year)
(c) Place: Burial or cremation Berrey Family Cemetery Audrain Co. Mo.
18. (a) Signature of funeral director McPherson Bros.
(b) Address Mexico Mo
19. (a) 2-15-1945 (Date received local registrar) (b) Margaret H Madrie (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15th year 1945 hour 9 PM minute ___ M.
21. I hereby certify that I attended the deceased from Jan 23 1945 to Feb 15 1945
that I last saw h__ alive on Feb 15 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage with left sided hemiplegia	1-23-45
Due to	
Due to Hypertensive Heart Disease	?
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy	

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Harry F O'Brien (M. D. or other)
Address Mexico Mo. Date signed 2-15-45

1074

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 3-45-480
Date Filed MAR 8 1945

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 .....

..... Registered Apprentice No. .....,

working under my personal supervision.

Signed J. E. McClanahan

Licensed Embalmer No. 1132

P. O. Address [illegible]

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 this body is not embalmed, fact should be so stated above.