

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

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(36671)

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 19 1946

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41761

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 185

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Charles  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Highway 40 at 9th & Clay Streets  
(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

3. (a) PRINT FULL NAME Emma Berry

3. (b) If veteran, name war NIL

3. (c) Social Security No. NIL

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Henry E. Berry, deceased

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 6 1873  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>9</u>	<u>2</u>	_____ hr. _____ min.

9. Birthplace Foristell Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business 1005 Jefferson Street

12. Name William Buerger

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Minnie ?

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Ernst Berry--Anna Buerger

(b) Address St. Charles, Missouri

17. (a) burial (b) Date thereof Dec 11-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation German Methodist St. Charles, Mo.

18. (a) Signature of funeral director H. C. Dallmayer, Dons Es

(b) Address 800 N. 2nd-St. Charles, Mo.

19. (a) Dec 17-46 (b) Nannie Deuel  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles

(c) City or town St. Charles  
(If outside city or town limits, write "RURAL")

(d) Street No. 1005 Jefferson Street  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8th day December  
year 1946 hour 6:15 minute A. M.

21. I hereby certify that I attended the deceased from held Inquest  
Sunday December 8-1946 4:00 P.M.  
and that death occurred on the date and hour stated above.

Immediate cause of death multiple injuries and shock resulting from accident

Due to automobile accident

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Dec. 8th 1946

(c) Where did injury occur? St. Chas. St. Chas. Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
highway 40-walking across street

While at work? no (Specify type of place) (e) Means of injury auto accident

23. Signature Walter J. ... Date signed 12-8-46

MOTHER FATHER

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

284

Date Filed 12-16-46

District File Number

District Health Officer No. 9

RECEIVED

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 Joseph I Landolt  
Licensed Embalmer No. 4189

P. O. Address St. Louis

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.