

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **2372**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

15

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 4611 Louisiana		d. STREET ADDRESS (If rural, give location) 4611 Louisiana	

3. NAME OF DECEASED (Type or Print) Emma Berry			4. DATE OF DEATH (Month) (Day) (Year) 3/20/49		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 14, 1875		9. AGE (In years last birthday) 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Robert Brisker		13b. MOTHER'S MAIDEN NAME Harriette Bryan		14. NAME OF HUSBAND OR WIFE John 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. --		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS John Berry--4611 Louisiana	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL HEART DISEASE WITH ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH
	DUE TO (b) CHRONIC NEPHRITIS WITH MORBID CONDITIONS, RISE TO THE ABOVE CAUSE (a) STATING THE UNDERLYING CAUSE LAST		
	DUE TO (c) CHRONIC CHOLECYSTITIS WITH CHRONIC HEPATITIS WITH CHRONIC DIABETES		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11/18, 1948, to 3/20, 1949, that I last saw the deceased alive on 3/16, 1949, and that death occurred at 3:20 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. W. Jackson M.D.		23b. ADDRESS 4661st VIRGINIA		23c. DATE SIGNED 3/21/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 3/23/49		24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	
		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri			

DATE REC'D. BY LOCAL REG. OFF. APR 21 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Wacker-Heiderle 3634 Gravois	
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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.

Signed Robert C Wheeler

Signed.....
Student Embalmer

Licensed Embalmer No. 2128

P. O. Address Shawano 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 this body is not embalmed, fact should be so stated above.