

No. 300  
10-48

FILED AUG 24 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27328

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 5568 Registrar's No. 299

1. PLACE OF DEATH a. COUNTY Jackson (Blue) 0480		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Inter-City c. LENGTH OF STAY (in this place) 24 hrs.		c. CITY (If outside corporate limits, write RURAL and give township) Inter-City (Blue) d.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8830 Winner Rd		d. STREET ADDRESS (If rural, give location) 8830 Winner Rd	

3. NAME OF DECEASED (Type or Print) Harriett Berry			4. DATE OF DEATH (Month) (Day) (Year) Aug 11, 1951		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 27, 1861	9. AGE (In years) (Months) (Days) (Hours) (Mins.) 90	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Richmond, Mo	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Frank M. Howell	13b. MOTHER'S MAIDEN NAME Henrietta Miller	14. NAME OF HUSBAND OR WIFE Curtis Berry
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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. None	17. INFORMANT'S SIGNATURE OR NAME Miss Henrietta Berry	ADDRESS 8830 Winner
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days  10 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility DUE TO (c)		
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 checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from Aug 10, 1951, to Aug 10, 1951, that I last saw the deceased alive on Aug 10, 1951, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE Fred W. Smith, M.D.	(Degree or title)	23b. ADDRESS Kansas City - 3 - Mo	23c. DATE SIGNED 8/12/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 14, 1951	24c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory	24d. LOCATION (City, town, or county) (State) Kansas City, Mo
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DATE REC'D BY LOCAL REG. 8-13-51	REGISTRAR'S SIGNATURE James H. Smith	25. FUNERAL DIRECTOR'S SIGNATURE Wilson L. Papp	ADDRESS Judge Mo
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(Licensed Embalmers' Statement on Reverse Side)

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

AUG 22 RECD

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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 \_\_\_\_\_

working under my personal supervision.

Signed.....  
Student Embalmer

Student Embalmer No.....

Signed.....

Licensed Embalmer No..... 4225

P. O. Address..... Indpls 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.