

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

BIRTH NO. 71 REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 20

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

1. PLACE OF DEATH a. COUNTY <u>Wernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington Twp</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>0510</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hosp # 3</u>		d. STREET ADDRESS (If rural, give location) <u>Mayview 1</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Alvin</u> b. (Middle) <u>W.</u> c. (Last) <u>Beringer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 16 1953</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1905</u>
9. AGE (In years last birthday) <u>47</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Geo. W. Beringer</u>	13b. MOTHER'S MAIDEN NAME <u>Josephine Albright</u>	14. NAME OF HUSBAND OR WIFE
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>4201</u>	17. INFORMANT'S SIGNATURE OR NAME <u>State Records</u> ADDRESS <u>Nevada Mo</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia Precox</u>		

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) (Min)	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 1 1950, to Jan 16 1953, that I last saw the deceased alive on Jan 15 1953, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title)	23b. ADDRESS <u>Nevada Mo</u>	23c. DATE SIGNED <u>1-16-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1-17-53</u>	24c. NAME OF CEMETERY, OR CREMATORY <u>Hospital Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Nevada Mo</u>
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DATE REC'D BY LOCAL REG. <u>1-29-53</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Nevada Mo</u>
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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 ^{*not*} embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed *Marl Eiche*.....

Licensed Embalmer No. *2656*.....

P. O. Address *Devala 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.