

FILED SEP 6 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28119**
7542
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Missouri				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) 22 days		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Chronic Hospital				e. STREET ADDRESS (If rural, give location) 19 3685a Laclede 2199			
3. NAME OF DECEASED (Type or Print) a. (First) Emma		b. (Middle) _____		c. (Last) Berry		4. DATE OF DEATH (Month) (Day) (Year) 8/14/56	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH 8/17/85	
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months _____ Days _____		IF OVER 1 YEAR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) / Cairo Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Johnson		13b. MOTHER'S MAIDEN NAME Rose ?		14. NAME OF HUSBAND OR WIFE William (Deceased)			
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. Yes		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Chronic Hospital 5600 Arsenal			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anaplastic Carcinoma of Left Breast with metastasis to dorsal spine ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Left Breast with metastasis DUE TO (c) To dorsal spine II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 yrs? 6 months	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 170 X				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 7/23 , 19 56 , to 8/14 , 19 56 , that I last saw the deceased alive on 8/14 , 19 56 , and that death occurred at 4:25A m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) George M. Tanaka, M.D.				23b. ADDRESS 5600 Arsenal Street		23c. DATE SIGNED 8/14/56	
24a. BURIAL, CREMATION-REMOVAL (Specify) Removal		24b. DATE 8-17-1956		24c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		24d. LOCATION (City, town, or county) (State) East St. Louis, Ill.	
DATE REC'D BY LOCAL REG. AUG 14 1956		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLAUGHLIN F.H., Inc. 2301 Lafayette			

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

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..

Student.....
Signature of Student Embalmer

Signed *James R. Chapman*.....

Licensed Embalmer No. *455*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. ...

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