

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039613**

**FILED VS. DEC 7 1959 28**

Registration District No. 2000 Primary Registration District No. 1289 Registrar's No. 1289

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Santa Rose</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>24 hrs.</b>		c. CITY OR TOWN <b>Milton</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Route #1</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>F.</b> Last <b>Berrian</b>				4. DATE OF DEATH Month <b>nov.</b> Day <b>27</b> Year <b>1959</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>25 Sept. 31 28</b>	9. AGE (last birthday) <b>28</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>soldier</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (City and state or country) <b>Milton, Florida</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Dewey Berrian</b>			13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>				
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes Apr. 55-58 July 59 Nov 59</b>			16. SOCIAL SECURITY NO. <b>267-42-5685</b>		17. INFORMANT Address <b>U.S. Army Ft. Leonard Wood, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive Cerebral Laceration and Hemorrhage</b> DUE TO (b) <b>Bullet wound of Brain</b> DUE TO (c) <b>36 hr approx.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input checked="" type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <b>11-25-59</b> a.m. p.m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Ft. Leonard Wood, Miss</b>		20f. CITY, TOWN, OR LOCATION <b>Ft. Leonard Wood, Pulaski, Mo</b>		COUNTY		STATE	
21. I attended the deceased from <b>11-26-59</b> to <b>11-27-59</b> and last saw her/him alive on <b>11-27-59</b> Death occurred at <b>11-27-59 1:10 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>John G. K. [Signature]</b> (Declarant or title)				22b. ADDRESS <b>1636 South [Address]</b>		22c. DATE SIGNED <b>12-2-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>unknown</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Milton Cemetery</b>		23d. LOCATION (City, town, or county) <b>Milton, Santa Rose Co., Fla.</b>					
24. FUNERAL DIRECTOR <b>J. G. Shady</b> ADDRESS <b>Lebanon, Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>12-2-59</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 1 1961

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 Walter C. Simpson

Licensed Embalmer No. 5071

P. O. Address \_\_\_\_\_

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.