

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-014175**

FILED VS. MAY 9 1960 38 Registration District No. Primary Registration District No. 3006 Registrar's No. 263

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>BOONE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BOONE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>COLUMBIA</b>		Length of stay in 1b <b>4 yrs</b>	c. CITY OR TOWN <b>COLUMBIA</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>29 South 2nd St</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>206 Cherry St</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>BERTON</b> Last			4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1960</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1903</b>	9. AGE (last birthday) <b>56</b>	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>DISHWASHER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>BOONE COUNTY, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>LEUIS BERTON</b>	13b. MOTHER'S MAIDEN NAME <b>WINNIE DORSEY</b>	14. NAME OF HUSBAND OR WIFE <b>CURLEY BERTON</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT <b>CURLEY BERTON, 206 Cherry St, Columbia</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>SUFFOCATION</b>		<b>MINUTES</b>
DUE TO (b) <b>ACUTE ALCOHOLISM</b>		<b>HOURS</b>
DUE TO (c)		
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 checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>DECEASED BECAME INTOXICATED AND</b>
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20c. TIME OF INJURY <b>Approx 9 p.m. April 30 60</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	20e. CITY, TOWN, OR LOCATION <b>COLUMBIA</b>	COUNTY <b>BOONE</b>	STATE <b>MISSOURI</b>
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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>Home</b>	20f. CITY, TOWN, OR LOCATION <b>COLUMBIA</b>	COUNTY <b>BOONE</b>	STATE <b>MISSOURI</b>
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21. I attended the deceased from **approx 9 p** to **9 p** and last saw her/him alive on **approx 9 p** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Vincent P Perre MD Coroner</b>	(Degree or title)	22b. ADDRESS <b>Univ. of Mo. Med Center</b>	22c. DATE SIGNED <b>3 May 60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/15/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	23d. LOCATION (City, town, or county) (State) <b>Columbia, Mo.</b>
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24. FUNERAL DIRECTOR <b>Mrs Stuart Parker, Columbia, Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>May 4 1960</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 George D. Vrammel

Licensed Embalmer No. 4425

P. O. Address Columbus, Ohio

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.