MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

18279

2382

1. PLACE OF DEATH

County Jackson — Registration District No. ..... — File No. .....

Township Kaw — Primary Registration District No. ..... — Registered No. .....

City Kansas City (No. St. Lukes Hosp. St. ..... Ward)

2. FULL NAME Hanna Sarah Berger

(a) Residence. No. 4100 Michigan St., 15 Ward. (Usual place of abode) ..... (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 23, 1908

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	19	1	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City (STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Harry Berger

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Russia

12. MAIDEN NAME OF MOTHER Gussie Fogel

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Romania

14. INFORMANT Harry Berger (Address) 4100 Michigan

15. FILED 6/11, 1927 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-10 1927

17. I HEREBY CERTIFY, That I attended deceased from June 9th, 1927, to June 10th, 1927 that I last saw her alive on June 9th, 1927, and that death occurred, on the date stated above, at 11 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Stenosis & Auricular fibrillation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) P. T. Bohan, M. D

6/11/27 19 (Address) 906 Medical Arts Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt. Carmel	6-12-1927
20. UNDERTAKER	ADDRESS
J. P. Louis	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.