

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

Do not use this space.

15829
45559

1. PLACE OF DEATH

County Stoddard

Registration District No. 837

File No. 15829

Township Richland

Primary Registration District No. 1101

Registered No. _____

City _____ (No. _____)

St. _____ Ward _____

2. FULL NAME

Albert S. Berger

(a) Residence No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

12-5-1879

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>48</u>	<u>4</u>	<u>9</u>	<u>-</u>

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

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

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

10. NAME OF FATHER

John S. Berger

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER

Elizabeth Hazel

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

14. INFORMANT (Address)

Daisy S. Berger

15. FILED

19 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-14 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 5 o'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Double Lobar Pneumonia
IIA
IOB
Infection, Influenza
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. S. Davis, M. D.

, 19 _____ (Address) Bloomfield

*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

Bloomfield Cemetery 4-15 1928

20. UNDERTAKER ADDRESS

J. A. Childs Bloomfield

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

