

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

Do not use this space.

763

1929

1. PLACE OF DEATH

County Cole
Township Jefferson
City Jefferson (No. _____)

Registration District No. 213
Primary Registration District No. 3014

File No. _____
Registered No. 44
St. _____ Ward _____

2. FULL NAME

Otto Bergman
(a) Residence No. 315 W. Miller St., _____ Ward _____
(Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 7, 1850

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 9 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fruit grower
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Baden
(STATE OR COUNTRY) Germany

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Dont know

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Dont know

14. INFORMANT Mrs Maggie Bergman
(Address) 315 W. Miller

15. FILED 2.13.29 Suburban REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1929 to Jan 31 1929 that I last saw him alive on Jan 31 1929, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
(duration) yrs. mos. ds. 3

CONTRIBUTORY (SECONDARY)

1010 (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, _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Mrs. A. A. A., M. D.
July 1929 (Address) St.

*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 Parvin Cem DATE OF BURIAL 2/3 29

20. UNDERTAKER Lawson Tamm ADDRESS J.C.M.

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.

21 1929
26
33
8
78-9-24
5
10
31
31

WHITE INK, WITH COPYING INK—THIS IS A PERMANENT RECORD

... of information should be carefully supplied. AGE should be entered. PHYSICIAN ...
... that it only be recorded clearly. ... OCCASION is ...

100

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Calo.

Registration District No. 213

File No.

Township

Primary Registration District No. 3014

Registered No. 414

City Jefferson (No.)

St. Ward)

2. FULL NAME

Otto Bergman

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 7 - 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 | 9 | 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

FILED 213, 1929 Sw Bedford

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1929

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D. , 19 (Address)

*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

19

20. UNDERTAKER ADDRESS

PRINT WITH "VOIDING INK" THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

763