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

Do not use this space.

7928

**1. PLACE OF DEATH**

County St. Louis — Registration District No. 1123 — File No. —

Township Carondelet — Primary Registration District No. 6248 B — Registered No. 79

City Koch (No. Koch Hosp. St. Ward)

**2. FULL NAME** John Bernds

(a) Residence. No. 1129 N 7th St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred X yrs. 4 mos. 28 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) |
|---|---|---|
| Male | White | Single |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 18 1865

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 64 | 3 | 28 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(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): Missouri

PARENTS

10. NAME OF FATHER: Herman Bernds

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

12. MAIDEN NAME OF MOTHER: Unknown

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

14. INFORMANT: Koch Hospital Records
(Address) Koch Mo.

15. FILED Feby 17 1929 L. C. Obrock M.D. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 16 1929 19

17. I HEREBY CERTIFY, That I attended deceased from Nov. 3 1928, 19, to Feb. 16 1929, 19 that I last saw him alive on Feb. 16, 1929, and that death occurred, on the date stated above, at 9:45 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

23 Pulmonary Tuberculosis

25

31

About (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Gastro Intestinal Tuberculosis

About (duration) yrs. 1 mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X Ray & Sputum

(Signed) R. L. Ehrlich, M. D.

2/16/29 (Address) Koch Hospital

*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: Calvary Cem. — DATE OF BURIAL: 2/19 19

20. UNDERTAKER: A. J. Donnelly — ADDRESS: St. Louis

# 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 St Louis — Registration District No. 1123 — File No.

Township Carondelet — Primary Registration District No. 6248B — Registered No. 79

City (No. , St. Ward)

2. FULL NAME John Bernds

(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| M | W | S |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 18, 1865

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 63 | 3 | 28 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS

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)

15. FILED Oct. 3, 1929 L. C. Obrock M.D. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 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:

(duration) 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?

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 |

SUPPLEMENTARY

S-7928