

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

Do not use this space.

13314

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St. Louis* (No. *1925 Wyoming*) St. _____ Ward _____

File No. _____
Registered No. **3881**

2. FULL NAME

(a) Residence. No. *1925 Wyoming St.* *524* 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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Divorced</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Catherine Bergman</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Mar 29 1860</i>		
7. AGE	YEARS	MONTHS
	<i>69</i>	<i>0</i>
		<i>0</i>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work. <i>Labourer</i>		
(b) General nature of industry, business, or establishment in which employed (or employer). <i>Retired</i>		
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Mo</i>		
PARENTS	10. NAME OF FATHER <i>August Bergman</i>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>	
	12. MAIDEN NAME OF MOTHER <i>Unknown Heimbach</i>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>	
14. INFORMANT <i>Caroline Hochm</i> (Address) <i>1925 Wyoming</i>		
15. FILED <i>31 1929</i> <i>Max W. Stahler</i> 19 _____ REGISTRAR		

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 29 1929*

17. *6-4* I HEREBY CERTIFY, That I attended deceased from *1928*, to *3-29*, 19 *29*
that I last saw him alive on *3-28*, 19 *29*, and that death occurred, on the date stated above, at *7:10 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*MYOTONIC LATERAL SCLEROSIS
C (MYOTONIA ATROPHICA)*
(duration) *10* yrs. - mos. - ds.

CONTRIBUTORY *ARTERIO-SCLEROSIS + MYOCARDIAL DEGENERATION chronic*
(SECONDARY) (duration) _____ yrs. - mos. - ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS *(ATROPHIC MUSCLES)*
(Signed) *Math E. Frank M.D.* M. D.
3-19 1929 (Address) *1405 S. Barry*

*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 <i>St. Peters</i>	DATE OF BURIAL <i>Apr 1 1929</i>
20. UNDERTAKER <i>Wacker-Helders</i>	ADDRESS <i>2331 S. Bldg</i>

WRITE PAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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