

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

Do not use this space.

16684

1. PLACE OF DEATH

County _____ Registration District No. 791
 Township _____ Primary Registration District No. 1002
 City St. Louis, Mo. (No. 2306 - Cherokee St.) St. _____ (Ward)

File No. _____
 Registered No. 4790

2. FULL NAME Fred Bergmann

(a) Residence. No. 2306 1/2 Cherokee St. 13 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 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 28 - 1878

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>50</u>	<u>5</u>	<u>27</u>	

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

10. NAME OF FATHER Wm Bergmann

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

12. MAIDEN NAME OF MOTHER Minnie Sharp

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

14. INFORMANT Rose Bergmann (Address) 2306 1/2 Cherokee St.

15. FILED APR 26 1929 Wm C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 25 - 1929

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1929, to April 25, 1929, that I last saw him alive on April 25, 1929, and that death occurred, on the date stated above, at 6:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tubercular Laryngitis
2 1/2 A (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTACTED _____ IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical Findings
 (Signed) Lois Moeller, M. D.

4/25, 1929. (Address) 3537 S. Jefferson

*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 High Ridge Mo. DATE OF BURIAL 4-27-1929

20. UNDERTAKER Ziegenhain Bros. 2623 Cherokee St. ADDRESS

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.

10-10-1-237

