

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

Do not use this space.

41808

1. PLACE OF DEATH

County Ray Registration District No. 748
Township Freshly Run Primary Registration District No. 6237
City Excelsior Springs (No. _____) St. _____ Ward _____

File No. _____
Registered No. 53

2. FULL NAME

William S. Berger
(a) Residence. No. Ray Co St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 52 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 Married
6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 26 1862
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 6 7
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) General farming
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) Ill.

10. NAME OF FATHER Christen Berger
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Penn
12. MAIDEN NAME OF MOTHER Kathern Hannah
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Penn

14. INFORMANT Frank Berger
(Address) _____

15. FILE Dec 24 19 29 L. E. Ellis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 22 1929
17. I HEREBY CERTIFY, That I attended deceased from 12-22 1929 to 12-22 1929
that I last saw alive on 12-22 1929 and (that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Coriary failure

CONTRIBUTORY (SECONDARY) Septic Throat (duration) _____ yrs. mos. ds.
Heart (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? clinical
(Signed) J. C. Beard M. D.

*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 Progab Cemetery DATE OF BURIAL Dec 24 19 29
20. UNDERTAKER John C Prather ADDRESS City Spgs

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important.

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