

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

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No..... **791**  
Township..... **ST. LOUIS** Primary Registration District No..... **1003**  
City..... (No. **ST. JOHN HOSPITAL**)..... St..... Ward.....

**6889**  
File No.....  
Registered No. **1739**  
St..... Ward.....

**2. FULL NAME**

**ROBERT THOMAS BERNDT**

(a) Residence. No. **6943 IDAHO AVE** St. **1** 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) \_\_\_\_\_

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **FEB. 10, 1930**

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, ..... hrs. or ..... min.
			<b>7</b>	

**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) **ST. LOUIS MO.**

PARENTS

10. NAME OF FATHER **JOSEPH P. BERNDT**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **ST. LOUIS MO.**

12. MAIDEN NAME OF MOTHER **MARY ALICE SMITH**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **ST. LOUIS MO.**

**14.**

INFORMANT **JOSEPH P. BERNDT**  
(Address) **6943 IDAHO AVE**

**15.**

FILED **19** **MAY 11 1930**  
REGISTRAR **May C. Harker**

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **FEB 17 1930**

17. **No. Physician in attendance**  
I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_, 19\_\_\_\_, m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: **450 a.**

**159**  
**86** **Convulsions**  
**Prone unknown**  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **(Premature Birth)**  
(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

**8** DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY **yes**

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) **C. W. Jones** M.D.

**2/19/30** address **Dep. Corona**

\*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**

**STURDY PRIVATE CEM. FEB 19 1930**

**20. UNDERTAKER**

**KRIEBSHAUSER UNAC 422 F ST. MARSHEN WAY**

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.

