

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

Do not use this space.

40936

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 5129² Wabada) St. Ward)

File No.
 Registered No. 11593

2. FULL NAME

Daniel J Berkold
 (a) Residence. No. St. 6 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Bertha Berkold</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>March 10th 1875</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>55</u>	<u>8</u>	<u>29</u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Post Office Clerk</u> (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....				

9. BIRTHPLACE (CITY OR TOWN)..... St. Louis
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Joseph Berkold</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... <u>Alsace</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Mary Gearin</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... <u>Ireland</u> (STATE OR COUNTRY)	

14. INFORMANT Mrs. Bertha Berkold
 (Address) 5129² Wabada Ave

15. FILED 15 1930 May 11 1930
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 9th 1930
 17. I HEREBY CERTIFY, That I attended deceased from December 5th, 1930 to December 9th, 1930
 that I last saw him alive on December 9th, 1930, and that death occurred, on the date stated above, at..... m.

108 THE CAUSE OF DEATH* WAS AS FOLLOWS:
1112
Lobar pneumo-pneumonia
 (duration) yrs. mos. 6 ds.
 CONTRIBUTORY oedema of lungs
 (SECONDARY) (duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED? 101 W
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? no DATE OF.....
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Orval K. Delfiken M. D.
11/10/1930 (Address) 3148 Olive St.

*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 <u>Oak Grove</u>	DATE OF BURIAL <u>12-12 1930</u>
20. UNDERTAKER <u>Arthur J. Donnelly</u>	ADDRESS <u>2039 Ward St.</u>

WRITE PLAINLY 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.

1000 Obj. 1000

3180 1000

10 =