

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

Do not use this space

10596

File No. ~~876~~

Registered No. 9721

1. PLACE OF DEATH

County Linn
Township Clock
City Moscow Mills (No. _____) St. _____ Ward _____

Registration District No. 972

Primary Registration District No. 5662

2. FULL NAME

Mary Elizabeth Bergfeld

(a) Residence. No. _____ St. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | White | married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 9. L. Bergfeld

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 9, 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 | 4 | 26

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home 1935
(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) Illinois

10. NAME OF FATHER Fritz Jaramal

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Bergfeld

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT 9. L. Bergfeld
(Address) Moscow Mills, Mo

15. Miss [unclear] 1934 Shelburn

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 5, 1934

17. I HEREBY CERTIFY, That I attended deceased from 2-24-34, 1934, to 3-5-34, 1934, that I last saw h. e. alive on 3-5-34, 1934, and that death occurred, on the date stated above, at 9 P

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

108
131 / 108 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) hypertensive - chronic (duration) yrs. mos. da.

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

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) W. S. Harris, M. D.
, 19 (Address) Troy, Mo.

*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 Anderson Cemetery DATE OF BURIAL Mar 7 1934

20. UNDERTAKER David L. Forbush ADDRESS Winfield, Mo

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. APR 24 1934

