

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

Do not use this space.

OCT 11 1934

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**1. PLACE OF DEATH**

County .....  
Township .....  
City ..... (No. ....)

Registration District No. ....  
Primary Registration District No. ....

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

(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 0 yrs. 0 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 31 - 34

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
0 0 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. nil  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

FATHER 13. NAME Lawrence P. Burger

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Nettie ?

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Wm. P. ...

18. BURIAL, CREMATION, OR REMOVAL PLACE Bismarck Mo DATE Sept 15 1934

19. UNDERTAKER (ADDRESS) J. Brebeck

20. FILED FP 10 13 1934 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/12 34

22. I HEREBY CERTIFY, That I attended deceased from 8/31, 1934, to 9/12, 1934

I last saw him alive on 9/12 1934 Death is said to have occurred on the date stated above, at 8:00 m.

The principal cause of death and related causes of importance were as follows:

touch pneumonia  
with

Other contributory causes of importance:

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

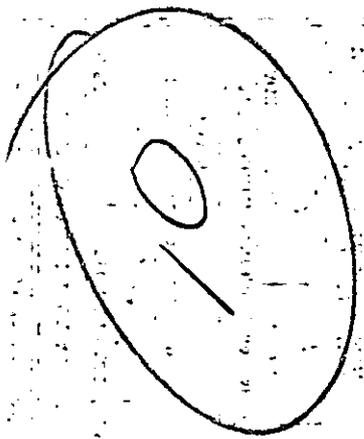
Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? If so, specify .....

(Signed) D. D. ..., M. D.  
(Address) City ...

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.



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St Louis City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: (In font) Barger  
Who died at City Hosp #1 on Sept 12 - 1934  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex F Color or race W Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years 0 Months 0 Days 12

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month Primary Branch Year Presumably  
Birthplace (State or country) \_\_\_\_\_  
Birthplace of father (State or country) \_\_\_\_\_  
Birthplace of mother (State or country) \_\_\_\_\_  
Principal cause of death: \_\_\_\_\_

Other contributory causes of importance \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
If death was due to external causes (violence) fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
Name of physician D. B. Elrod  
Address of physician City Hosp #1

X Signature of Registrar J. A. Budek Date filed Nov 2 - 34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours E. T. McLaugh  
State Registrar

Reg. Dist. No. \_\_\_\_\_  
Primary Reg. Dist No. \_\_\_\_\_

Special Agent.

S-34369