

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

Do not use this space.

JUN 29 1937

1. PLACE OF DEATH

96 County St. Louis
Township
City University (No. 6600 Washington Ave.)

Registration District No. 1160
Primary Registration District No. 4470

File No. 21399
Registered No. 52
St. _____ Ward _____

2. FULL NAME Louise Bergen

(a) Residence, No. 6600 Washington 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Patrick J. Bergen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sep. 9, 1838

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
98 8 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At home
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.

13. NAME Not known

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT George Bergen (ADDRESS) 6110a Lotus Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Bellefontaine DATE May 25, 1937

19. UNDERTAKER (ADDRESS) 2707 N. Grand St

20. FILED May 25 1937 Lena Mollen D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23, 1937

22. I HEREBY CERTIFY, That I attended deceased from May 21, 1937, to May 23, 1937. I last saw her alive on May 23, 1937. Death is said to have occurred on the date stated above, at 9:30 m.

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

Hypertatic Pneumonia

Date of onset May 20

Other contributory causes of importance Senility

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? No

If so, specify (Signed) J. R. Myers M. D. (Address) 607 N. Grand St

109

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

21399

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PLACE OF DEATH

(a) County St. Louis Registration District No. 1160
(b) Township _____ Primary Registration District No. 4470 Registered No. 52
(c) City University (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

PRINT FULL NAME: Kouse Bergen

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

DATE OF BIRTH (MONTH, DAY, AND YEAR)

AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
98 8 14

9. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

10. Industry or business in which work was done, as saw mill, bank, etc.

11. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

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

15. MAIDEN NAME

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

INFORMANT (ADDRESS)

BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19__

FUNERAL DIRECTOR (ADDRESS)

FILED 19__

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23 1937

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19__

I last saw h. _____ alive on _____, 19__ Death is said to have occurred on the date stated above, at _____ m.

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

Hypertensive Pneumonia

Date of onset

Other contributory causes of importance:

Senility

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) T. R. Ayers M. D.

(Address) 607 N Grand St.

SUPPLEMENTARY

S-21399