

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

2142

State File No. _____

Registration District No. 134

Primary Registration District No. 5204

Registrar's No. _____

1. PLACE OF DEATH:

(a) County: Carroll
 (b) City or town: Rural Miami Sup.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME: Peter Bargold
 3. (b) If veteran, name, war: _____
 3. (c) Social Security No.: _____

4. Sex: M. 5. Color or race: W
 6. (a) Single, widowed, married, divorced: Married
 5. (b) Name of husband or wife: Beatrice Denham
 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: June 23 1866
 (Month) (Day) (Year)

8. AGE: Years: 74 Months: 6 Days: 22
 If less than one day: _____ hr. _____ min.

9. Birthplace: Parita Co. Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: _____

FATHER { 12. Name: Joseph Bargold
 13. Birthplace: Germany
 (City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name: Germany
 15. Birthplace: _____
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Mrs. Coy Brody
 (b) Address: Wakenda, Mo.

17. (a) Burial (b) Date thereof: 1-16-41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: Evergreen Cem.

18. (a) Signature of funeral director: Stamper
 (b) Address: Carrollton, Mo.

19. (a) Jan. 15-41 (b) Alte Henderson
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Carroll
 (c) City or town: Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No.: _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.: _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Jan day: 14
 year: 1941 hour: 6 minutes: 45 A. M.

21. I hereby certify that I attended the deceased from Jan 9-41
 _____, 19____, to Jan 14, 19____;
 that I last saw him alive on Jan 14, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Nephritis -
Secondary of Kidneys -
 Due to: hypertension

Due to: _____

Other conditions: _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____
 Of autopsy: _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): _____
 (b) Date of occurrence: _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury: _____

23. Signature: R. M. ... (M. D. or other) _____
 Address: Carrollton, Mo. Date signed: Jan 14, 41

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.

216

RECEIVED
District Health Officer No. 8,
17-10-8

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Ben W. Gibbs*

Licensed Embalmer No. *2961*

P. O. Address *Carrollton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

ALBANY DISTRICT HEALTH OFFICER

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2142

Registration District No. 136

Primary Registration District No. 5204

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Miami T.O.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Peter Bergold

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year _____

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

74

6

22

hr.

min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____

(b) _____

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

DEATH CERTIFICATION

20. DATE OF DEATH: Month Jan day 14
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____

that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis

Eden's Kidney

Due to Influenza

Due to Cold on a chronic nephritis

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL COPY

WRITE PLAINLY—USE UNFADING-BLACK INK—MAKE A PERMANENT RECORD

