

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILLED OCT 31 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36260

Registration District No. 7

Primary Registration District No. 4483

Registrar's No.

1. PLACE OF DEATH:

(a) County Schuyler  
(b) City or town Queen City  
(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 21 years (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME Elizabeth L. Bergman

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Robert Bergman 6. (c) Age of husband or wife if alive 79 years  
7. Birth date of deceased February 14 1871  
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 1 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Gorin Scotland Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Christian Rickenberg  
13. Birthplace Scotland Co Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Arnold  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Bergman  
(b) Address Queen City Mo.

17. (a) Burial (b) Date thereof Oct. 17, 41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
Queen City Mo.

(c) Place: burial or cremation Cemetery

18. (a) Signature of funeral director Morehead's  
(b) Address Manchester Mo.

19. (a) Oct 20-41 (b) Olive B Jones  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Schuyler  
(c) City or town Queen City  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 15  
year 1941 hour 4 minute 5 P M.

21. I hereby certify that I attended the deceased from Apr 15  
1941, to Oct 15, 1941;  
that I last saw her alive on Oct 15, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cancer of the Intestines  
Due to Breast Cancer Removal  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 2-50

23. Signature O.P. Jones (M., D., or other) DO  
Address Queen City Mo Date signed Oct 16

Duration  
6  
21  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

MAR 23 1949

AUG 5 1949

SEP 26 1949

RECEIVED

District Health Officer No. 10

District File Number 10-41-1949

Date Filed OCT. 30, 1949

### 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.....

Thos. Minnie Morehead

Registered Apprentice No. ....

working under my personal supervision.

Signed

Morehead

Licensed Embalmer No. 3680-3731

P. O. Address Lancaster, Mo.

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **36260**

Registration District No. **806**

Primary Registration District No. **4485**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Schuyler**  
(b) City or town **Queen City, Mo.**  
(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

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 \_\_\_\_\_ years  
7. Birth date of deceased **Feb 14 1911**  
(Month) (Day) (Year)

8. AGE: Years **70** Months **8** Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(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 **Mo.**  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year **1941** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death **Cancer of Intestine**  
Duration \_\_\_\_\_

Due to **Primary seat of malignancy = Breast.**  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 **O.P. Green** (M.D. or other) **DO**  
Address **Queen City, Mo.** Date signed **Dec 13 1941**

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

SUPPLEMENTARY

