

7. S. No. 2
FORM-5-43
Rev. 5-17-39

FILED MAY 9 1944
Registration District No. **1318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Hugo John Berg

3. (b) If veteran, name war None

3. (c) Social Security No. 703-16-3570

4. Sex Male **5. Color or race** White

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

6. (b) Name of husband or wife Catherine Berg

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased December 23 1877
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
66	4	3	hr. min.

9. Birthplace Dutzow Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Toolroom Attendant

11. Industry or business Mo-Pac R.R.

12. Name Gottlieb Berg

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Barbara Mann

15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Catherine Berg

(b) Address 923 S. Theresa Ave.

17. (a) Burial **(b) Date thereof** 4-30-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marthasville, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) APR 2 **(b)** J. T. Bredeek
(Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 923 S. Theresa
(If rural, give location)

(e) Citizen of foreign country?.....
(Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26
year 1944 hour 7 minute 10 P.M.

21. I hereby certify that I attended the deceased from 4-19, 1944, to 4-26, 1944;
that I last saw him alive on 4-26, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Esophagus

Due to.....

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 Harold Steele (M. D. or other).....
Address 1755 S. Grand Date signed 4-26-44
St. Louis, Mo

SEP 12 1945

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.....

R. W. Wilkinson

Licensed Embalmer No. *3575*

P. O. Address.....

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, fact should be so stated above.