V. S. No. 2
50M---5-42
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 26 1944

Registration District No. 199

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30004

State File No.

Primary Registration District No. 1602

Registrar's No. 3665

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 235 Ward Parkway
(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)
In this community: 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 235 Ward Parkway
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

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3. (a) PRINT FULL NAME: Sadie Spear Berg

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: Simon A. Berg

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

7. Birth date of deceased: July (Month) 17 (Day) 1874 (Year)

8. AGE: Years 70 Months 1 Days ~~24~~ 23 If less than one day hr. min.

9. Birthplace: Washington (City, town, or county) D. C. (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Leopold Spear
13. Birthplace: (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name: Esther Rosenberg
15. Birthplace: (City, town, or county) Pa. (State or foreign country)

16. (a) Informant: Mrs Sara Goodfriend
(b) Address: 235 Ward Parkway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/12/44 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Joseph Mo.

18. (a) Signature of funeral director: Carroll- Davidson
(b) Address: 3024 Troost av.

19. (a) 9-11-44 (Date received local registrar) (b) M. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 10 year 1944 hour 11 minute 20 A.M.

21. I hereby certify that I attended the deceased from October, 1942, to Sept 10, 1944, that I last saw her alive on Sept. 10, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary edema; Myocardial failure	24 hr. 10 days
Due to: Generalized Carcinomatosis	2 yr.
Due to: Carcinoma of Breast	3 yr.
Other conditions (Include pregnancy within 3 months of death): 50	
Major findings: Of operations: Carcinoma of Breast	
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: Cecil M. Kohn M.D. (M. D. or other)
Address: 630 Ang. Bldg. Date signed: 9/11/44

(Licensed Embalmer's Statement on Reverse Side)

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 Kathryn E. Davidson

Licensed Embalmer No. 3648

P. O. Address Kansas City

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.