

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 8 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10092

Registration District No. 179

Primary Registration District No. 3671

Registrar's No.

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Rural Prairie Twp.
(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 _____
In this community In This Community
years, months or days 12 yr. (Specify whether)

3. (a) PRINT FULL NAME SUSAN MAY BERGESCH

3. (b) If veteran, name was None 3. (c) Social Security No. None

4. Sex F 5. Color or race W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 2 years
7. Birth date of deceased May 1 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 10 Days 4
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____
12. Name Richard Keith
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Taylor
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Paul Bergesch
(b) Address New London

17. (a) Burial (b) Date thereof 3-10-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson Hill Cem

18. (a) Signature of funeral director Wayne McShay

(b) Address Irish Run

19. March 20/45 (b) Tamara McQueen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln
(c) City or town Rural
(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 March Day 5
year 1945 hour 11 minute 20 P.M.

21. I hereby certify that I attended the deceased from Nov. 1943 to March 5 1945
that I last saw her alive on March 5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Duration _____

Due to _____

Due to 136'

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) Means of injury _____

23. Signature V. E. Alford (M. D. or other) 20
Address Irish Run Date signed 3/6/45

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-6-45

APR 11 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.....

Licensed Embalmer No. 3084

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.