

S. No. 2
OM-543
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25429**

FILED AUG 29 1945

Registration District No. _____ Primary Registration District No. **L 200**

Registrar's No. **7046**

1. PLACE OF DEATH:

(a) County **St. Louis, Mo.**
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Barnes Hospital.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4397 West Pine Blvd.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MARTHA ALVIRA BERGMAN**

3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **None**

4. Sex **Female** / 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Carl Bergman** 6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **April 7 1905**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	40	4	2	hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **William Wofford**

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

14. Maiden name **Amy McCauley**

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

16. (a) Informant **Carl Bergman**

(b) Address **4397 West Pine Blvd.**

17. (a) **Burial** (b) Date thereof **8-12-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Salem, Missouri**

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

(b) Address **4700 Washington Blvd.**

19. (a) **AUG 19 1945** (b) **J. P. Brubaker**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **9**
year **1945** hour **9** minute **35** a.m.

21. I hereby certify that I attended the deceased from **JULY 11,**
1945 to **AUGUST 9, 1945**
that I last saw her alive on **AUGUST 9, 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho pneumonia**
Duration **3 days**

Due to **leukosarcoma LEUKEMIA** **1 yr +**

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) **74**

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 _____
Signature **J. P. Brubaker** (M. D. or other) _____
Address **Barnes Hospital,** Date signed **8-9-45**

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

JUL 28 1945

SEP 10 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.....

G. 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.