

FILED JUL 17 1948

Registration District No. _____

Primary Registration District No. 3012Registrar's No. 87

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Excelsior Springs, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Veterans Administration Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9 days
 (Specify whether years, months or days)
 In this community 9 days

3. (a) PRINT

FULL NAME Carl Bergman

3. (b) If veteran,

name war WW II

3. (c) Social Security

No. unknown

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife unknown
 6. (c) Age of husband or wife if alive unknown years
 7. Birth date of deceased June 1 1900
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 1 0 hr. min.

9. Birthplace Avoca, Iowa
 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farming

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Hospital records

(b) Address VA Hospital, Excelsior Springs, Mo.

17. (a) removal (b) Date thereof 7/1/48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Avoca, Iowa

18. (a) Signature of funeral director JOHN FUNERAL HOME

(b) Address Excelsior Springs, Missouri

19. (a) 7/1/48 (b) Karoline Buchholz
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Unknown
 (c) City or town Avoca
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
 year 1948 hour 5 minute 28P M.

21. I hereby certify that I attended the deceased from 6/22, 1948, to July 1, 1948;
 that I last saw him alive on July 1, 1948;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration unknown

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: Of operations NO OPERATIONS

Of autopsy Not done

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) No

(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

23. Signature Jack M. Hoagard (M. D. or other)
JACK D. LEOPARD, M. D.
 Address Veterans Admn. Hospital Date signed 7/1/48

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 7-16-48

686. 22 907

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 James A. Moles

Licensed Embalmer No. 3296

P. O. Address Ex Springs, Pa.

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.