

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

24515

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 231

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Francois</u> OR TOWN <u>RURAL</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Desloge</u> OR TOWN <u>Desloge</u>	
c. LENGTH OF STAY (In this place) <u>13Y; 1M; 16</u>		d. STREET ADDRESS (If rural, give location) <u>Unknown</u>	
d. FULL NAME OF (If not in hospital or institution, give street address of location) HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>M.</u> c. (Last) <u>BERGHOEFFER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 3, 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	
8. DATE OF BIRTH <u>June 19, 1902</u>		9. AGE (In years last birthday) <u>47</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (invalid)</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington County, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Charles H. Berghoefer</u>		13b. MOTHER'S MAIDEN NAME <u>Theodocia Miller</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Records State Hospital No. 4, Farmington, Mo.</u> ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho pneumonia, terminal</u> ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) <u>Infantile Paralysis (invalid)</u> rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Psychosis with infantile paralysis.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>Years.</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov. 7, 1948, to July 3, 1949, that I last saw the deceased alive on July 3, 1949, and that death occurred at 4:20A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Phillip Brennan, M.D.</u>		23b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u>		23c. DATE SIGNED <u>Mo. 7-4-49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 7, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Farmington, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>July 6, 1949</u>		REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. Z. Boyer & Son, Desloge, Mo.</u> ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

943

943

RECEIVED 8-1-49

District Health Officer No. 4

District File Number 849-103

Date Filed.....

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed B. T. Boyer.....

Signed.....
Student Embalmer

Licensed Embalmer No. 3660.....

P. O. Address Desloge, Mo......

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.