

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9159

State File No.

No. 300
10.48

FILED MAR 25 1953

BIRTH NO. _____		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>31</u>	
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Iowa</u> b. COUNTY <u>Polk</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		c. LENGTH OF STAY (In this place) <u>5 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Des Moines</u>		<u>8140</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The Ball Clinic</u>				d. STREET ADDRESS (If rural, give location) <u>2206 York Street</u>			
3. NAME OF DECEASED (Type or Print) <u>ENOCH</u>		a. (First)		b. (Middle)		c. (Last) <u>BERGSTROM</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>March, 19, 1953</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	
8. DATE OF BIRTH <u>Nov. 7, 1887</u>		9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months Days		IF UNDER 1 HR. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Construction</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Hulda Bergstrom</u>			
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>Yes. (Unk)</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>H.A. Bergstrom, Des Moines, Iowa.</u> <u>1712 26th St.</u>			
MEDICAL CERTIFICATION							
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiac asthma</u>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4342</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>3-19</u> , 19 <u>53</u> , and that death occurred at <u>9:40 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u>				23b. ADDRESS <u>Excelsior Springs, Ia.</u>		23c. DATE SIGNED <u>3-20-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3-20-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		24d. LOCATION (City, town, or county) (State) <u>Des Moines, Iowa.</u>	
DATE REC'D BY LOCAL REG. <u>3/20/53</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		FUNERAL DIRECTOR'S SIGNATURE <u>David Richard</u>		ADDRESS <u>Excelsior Springs, Mo.</u>	

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

002
0

MAR 8 1958

APR 11 1958

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.

Student
Student Embalmer

Signed Lindell K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, 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.