

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13182**
Registrar's No. **3661**

FILED MAY 4 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Northwoods 4 150	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hospital		e. STREET ADDRESS (If rural, give location) 5423 Fletcher	

3. NAME OF DECEASED (Type or Print)	a. (First) Henry	b. (Middle) P.	c. (Last) Berg	4. DATE OF DEATH (Month) (Day) (Year) April 22, 1954
-------------------------------------	-------------------------	-----------------------	-----------------------	---

5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W.	8. DATE OF BIRTH Jan. 10, 1881	9. AGE (In years) (Months) (Days) 73	IF UNDER 1 YEAR 3 Months	IF UNDER 24 HRS. 12 Hours
------------------	----------------------------	--	---------------------------------------	---	---------------------------------	----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plater	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.
---	-----------------------------------	--	--

13a. FATHER'S NAME Unk. Berg	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Mrs. Gertrude Berg
-------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mr. Henry F. Berg	ADDRESS 5423 Fletcher
---	-------------------------------	--	------------------------------

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7 days 10 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Vasculardis.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) 260 X
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 **4-20** 1954, to **4-22** 1954, that I last saw the deceased alive on **4-21**, 1954, and that death occurred at **4:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John L. Kennedy M.D. M.P.H.	23b. ADDRESS 8733 Riverview	23c. DATE SIGNED 4-23-54
---	------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 24, 1954	24c. NAME OF CEMETERY OR CREMATORY St. Paul's Churchyard	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
---	---------------------------------	---	--

DATE REC'D BY LOCAL REG. APR 23 1954	REGISTRAR'S SIGNATURE J. Carl Smith	FEDERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly	ADDRESS 3840 Lindell Blvd.
---	--	--	-----------------------------------

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

(Licensed Embellisher's Statement on Reverse Side)

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 me....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed W. J. [Signature].....

Licensed Embalmer No. 1234.....

P. O. Address [Signature].....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.