

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20191

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4403**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 1-wk.		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		e. STREET ADDRESS (If rural, give location) 15 4559 Morganford Rd. 21590			
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) F.		c. (Last) Bergmann	
4. DATE OF DEATH (Month) (Day) (Year) May 16, 1954		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 12, 1875		9. AGE (In years last birthday) 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired)		10b. KIND OF BUSINESS OR INDUSTRY Koochook Co.		11. BIRTHPLACE (City and State or Foreign Country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Josephine Thirouw Bergmann		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 489-05-5000	
17. INFORMANT'S SIGNATURE OR NAME Josephine Bergmann-		ADDRESS 4559 Morganford			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema ANTECEDENT CAUSES DUE TO (b) Cerebral Hemorrhage DUE TO (c) Cardiovascular renal disease 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		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) 442 X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 May 13, 1954 , to May 16, 1954 , that I last saw the deceased alive on May 16, 1954 , and that death occurred at 8:40 P m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Rayne V. Hunschel M.D.		23b. ADDRESS 6200 Hoffman Blvd		23c. DATE SIGNED 5/17/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE May 20, 1954		24c. NAME OF CEMETERY OR CREMATORY St. Trinity Lutheran Ceme.	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		DATE REC'D BY LOCAL REG. MAY 17 1954		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker - Kelderle - 3634 Gravois Ave.	

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

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.....
Signature of Student Embalmer

Signed *Robert Wheeler*.....

Licensed Embalmer No. *212*.....

P. O. Address *Memphis*.....

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.