

FILED OCT 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31894

State File No.

318

1003

Registrar's No. 8401

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8401				
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY St. Louis		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis			c. LENGTH OF STAY (In this place) 2 Hrs.		c. CITY OR TOWN Florissant		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION De Paul Hospital				STREET ADDRESS (If rural, give location) #22 Locust Dr.						
3. NAME OF DECEASED (Type or Print) Eleanor			a. (First)		b. (Middle) F.		c. (Last) Bergjans			
4. DATE OF DEATH			(Month) Sept		(Day) 10,		(Year) 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct 12, 1888		9. AGE (In years last birthday) 67		
IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 24 HRS. Hours _____		IF UNDER 24 HRS. Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Florian Lang			13b. MOTHER'S MAIDEN NAME Josephine Rensen			14. NAME OF HUSBAND OR WIFE August R. Bergjans				
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. None		17. INFORMANT'S SIGNATURE OR NAME August R. Bergjans				ADDRESS #22 Locust Dr.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage				DUPLICATE (b) Generalized Arteriosclerosis ± 15 yrs				2 1/2 hrs.		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				DUPLICATE (c) Atherosclerotic heart disease ± 10 yrs.						
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 checked="" 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) 420.0		21d. (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Minute) _____			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 Sept 1955, to Sept 1956, that I last saw the deceased alive on 9/10 1956, and that death occurred at 4:35 p.m., from the causes and on the date stated above.										
23a. SIGNATURE Walter L. Nixon				(Degree or title) M.D.		23b. ADDRESS Ferguson Mo.		23c. DATE SIGNED 9/11/56		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/13/56		24c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		24d. LOCATION (City, town, or county) Florissant		(State) Mo.		
DATE REC'D BY LOCAL REG. SEP 11 1956			REGISTRAR'S SIGNATURE Pearl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE Collier Mortuary			ADDRESS 10123 St. Charles Rd	

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

Dr. Hixon, Dr. Johnson's Office
40 N. FLORISSANT
JA 11302

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 *Sheldon Collier*.....

Licensed Embalmer No. *338*.....

P. O. Address *10123 St. M*.....

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.