

FILED DEC 5 - 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
4450

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5450

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI		c. CITY OR TOWN GRANDVIEW	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp. 9 days		d. STREET ADDRESS (If outside, give location) 19310, 11th St.	
3. NAME OF DECEASED (Type or print) First MIDDLE Last DAVID WAYNE BERGSCHNEIDER		4. DATE OF DEATH Month Day Year Nov 18 1957	
5. SEX MALE	6. COLOR OR RACE CAUS	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 3, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (In years last birthday) 3 15
11. BIRTHPLACE (City and state or country) MARYVILLE, TENN.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ETHAN ALLEN BERGSCHNEIDER		14. MOTHER'S MAIDEN NAME MONA JEAN STRINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Ethan A. Bergschneider		Address Grandview, Mo. 13310, 11th St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO (b) Hydrocephalus & Congenital Defect Brain DUE TO (c) Meningomyelocoele 1511			INTERVAL BETWEEN ONSET AND DEATH 1 week 3 months 15 days 3 months 15 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Nov-9-57 to Nov-17-57 and last saw him alive on Nov-17-57 Death occurred at 1:10 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Roy F Garrison M.D.		22b. ADDRESS 6509 Prospect	22c. DATE SIGNED Nov 18, 57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-19-57	23c. NAME OF CEMETERY OR CREMATORY Buckner Cem.	23d. LOCATION (City, town, or county) (State) Buckner Mo.
24. FUNERAL DIRECTOR Robert Funeral Home INC		25. DATE RECD. BY LOCAL REG. 11-19-57	26. REGISTRAR'S SIGNATURE Vera Marshall

300
1-56

All symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Roy F. Garrison

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1931

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 *Ralph G. Jones*.....

Licensed Embalmer No. *460*.....

P. O. Address *Odessa*.....

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.