

Health, Welfare & Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 13 1958

1152  
STATE FILE NUMBER 332

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

300 0  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson Lafayette</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lexington</b> <b>Kansas City</b>
c. FULL NAME OF (IF NOT in hospital, give location) <b>St. Mary's Hosp.</b>		Length of stay in lb <b>1 day</b>	d. STREET ADDRESS <b>2230 Summit</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>K.</b> Last <b>Berglund</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>14</b> Year <b>1958</b>		
--	--	--	---	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21, 1898</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Min. <b>0</b>
--------------------	-------------------------------	---	--	---	---	-----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (City and state or country) <b>Lexington, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	--	---	---

13a. FATHER'S NAME <b>Knute Berglund</b>	13b. MOTHER'S MAIDEN NAME <b>Amanda Holmgren</b>	14. NAME OF HUSBAND OR WIFE <b>_____</b>
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>495-09-7863</b>	17. INFORMANT <b>Jose Anderson, Lexington, Mo.</b>	Address
--	---	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebellar Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) <b>Old myocardial infarction</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
---	--	---

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 _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	--	------------------------------	--------	-------

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 \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Hugh H. Owens</b>	(Degree or title)	22b. ADDRESS <b>1034 Walnut Bldg</b>	22c. DATE SIGNED <b>1-15-58</b>
--	-------------------	---	------------------------------------

23a. BURIAL REMOVAL, REMOVED (Specify) <b>Burial &amp;</b>	23b. DATE <b>Jan. 16, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Marhpelah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Lexington, Mo.</b>
---	-----------------------------------	---	--

24. FUNERAL DIRECTOR <b>Melody-McGilley-Eylar Funeral Home</b>	ADDRESS <b>Woodland-Linwood</b>	25. DATE RECD. BY LOCAL REG. <b>1-23-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
---	------------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with 50 stated. All diseases in Part I must be causally related.

Hugh H. Owens

movav

*Dr. Hugh ...*



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 *John H. ...* .....

Licensed Embalmer No. *2929* .....  
P. O. Address *KC 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.