

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009006

STATE FILE NUMBER

FILED APR 14 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 230-A

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Springfield TOWN		c. CITY OR TOWN Springfield 6396 Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Hospital		Length of stay in 1b 2 weeks	
3. NAME OF DECEASED (Type or print) BERGEN		4. DATE OF DEATH Month March Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Feb. 6, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Salesman-Rawleigh & Furniture-Garrison, Mo.		11. BIRTHPLACE (City and state or country) U. S. A.	
13a. FATHER'S NAME George W. Adams		13b. MOTHER'S MAIDEN NAME Jane Nance	
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. 497227646	
17. INFORMANT Mrs. Florence Adams, Springfield, Mo.		14. NAME OF HUSBAND OR WIFE Florence Stinett	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral vascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture, hip, left			INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 334XF	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☐		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 3/10/59 to 3/26/59 and last saw her alive on 3/25/59 Death occurred at 7:10 a. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE E. Callaway, Jr MD (Degree or title)		22b. ADDRESS 1211 S. Glenstone Springfield, Missouri	
22c. DATE SIGNED 4/2/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/28/1959	
23c. NAME OF CEMETERY OR CREMATORY Garrison Cemetery		23d. LOCATION (City, town, or county) (State) Garrison, Missouri	
24. FUNERAL DIRECTOR John Harris ADDRESS Clever, Mo.		25. DATE RECD. BY LOCAL REG. 4-6-59	
		26. REGISTRAR'S SIGNATURE Effie G. Melton	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

6201 0 1 JES

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

Licensed Embalmer No. 4390
P. O. Address
Cleveland, 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.