

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039441

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2970

FILED NOV 8 1961

1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webster Groves</b>		Length of stay in 1b <b>YRS.</b>	c. CITY OR TOWN <b>Webster Groves</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>614 Clairmont Ave.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>614 Clairmont Ave.</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Carl</b> Last <b>Berg</b>			4. DATE OF DEATH - Month <b>Oct.</b> Day <b>23</b> Year <b>1961</b>			
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5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/76</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis City</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>John Berg</b>	13b. MOTHER'S MAIDEN NAME <b>Augusta Purfuerst</b>	14. NAME OF HUSBAND OR WIFE <b>Minnie K. Berg</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service): <b>no</b>	17. INFORMANT <b>Fred Berg, 614 Clairmont Ave.</b>
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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>Coronary Insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arterial Sclerosis Gen</b>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour <b>3</b> Month, Day, Year <b>11-23-61</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Kirkwood, Mo.</b>	STATE
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Kirkwood, Mo.</b>	STATE
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21. I attended the deceased from **Jan 19 30** to **11-23-61** and last saw **him** live on **11-23-61**  
Death occurred at **3 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Carl L. Erick M.D.</b> (Degree or title)	22b. ADDRESS <b>237 E. Locust St.</b>	22c. DATE SIGNED <b>11-23-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/25/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill</b>	23d. LOCATION (City, Town, or County) <b>Kirkwood, Mo.</b> (State)
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24. FUNERAL DIRECTOR <b>Parker-Aldrich, Webster Groves, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-23-61</b>	26. REGISTRAR'S SIGNATURE <b>June B. Murphy M.D.</b>
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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Lealie Welch

Licensed Embalmer No. 4395  
P. O. Address Wester Grove

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.