

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-043963

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11236**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 30 1962

VS 300
Rev. 4/59

1
2 *21*
3
4 *1*
5 *2*
6
7 *0*
8 *2*
9
10
11
12 *61-0*
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Amended - Ed Sarpy

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Desloge Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4129 Sarpy
3. NAME OF DECEASED (Type or print) ANNIE BERGMAN		First Middle Last	4. DATE OF DEATH November 21, 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (last birthday) 89
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Henry Cune		13b. MOTHER'S MAIDEN NAME Mary Felling	14. NAME OF HUSBAND OR WIFE Late August Bergman
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. No.	17. INFORMANT Marie Seiler Address 5318 Gilson
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia			INTERVAL BETWEEN ONSET AND DEATH 8 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Staphylococcus infection			? 2 wk.
DUE TO (c) 053.1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pyelonephritis, st. Diabetes mellitus & periph. vasc. disease			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 1954 to 1962 and last saw ^{her} him live on 20 Nov. '62 Death occurred at 5:20 P. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John Johnstone, Jr. M.D.</i> (Degree or title)		22b. ADDRESS 206 West Argonne	22c. DATE SIGNED 23 Nov 62 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/24/62	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S. Kingshighway		25. RECEIVED BY LOCAL REG. NOV 23 1962	
26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

*Mr. Johnstone 130
206 N. Oregon*

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 *R.W. Storey*

Licensed Embalmer No. *4007*

P. O. Address *St. Louis 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.