

FEAR 26 1928

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

2499

1. PLACE OF DEATH

County St. Louis Registration District No. 1170 File No. 1  
Township Central Primary Registration District No. 6248 H Registered No. 10  
City Richmond 496 St. Marys Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Margaret Bergert  
(a) Residence. No. 4467 Lee Ave St. \_\_\_\_\_ Ward. St. Louis, Mo.  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF August Bergert

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 24 - 1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
42 | 1 | 17 | |

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work House wife 35  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Ireland  
(STATE OR COUNTRY)

10. NAME OF FATHER James Barry

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Cronin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland  
(STATE OR COUNTRY)

14. INFORMANT (Address) Margaret Bergert  
4467 Lee Ave

15. FILED 1/12, 1928 C. L. Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10 - 1928

17. I HEREBY CERTIFY, That I attended deceased from 5 Jan, 1928, to 10 Jan, 1928, that I last saw h. s. alive on 12 noon, 1928, and that death occurred, on the date stated above, at 3 PM m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Respiratory Failure  
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Tumor Prostate  
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH his home

DID AN OPERATION PRECEDE DEATH? No DATE OF 1/5/28

19. WHAT TEST CONFIRMED DIAGNOSIS? Specimen

(Signed) James F. Clancy M. D.  
1/11/28, 19 (Address) Security Club

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cemetery DATE OF BURIAL Jan 14 28

20. URBERTAKER Strook & Carroll ADDRESS 4600 National Bldg 6

AGE should be properly classified. Exact date of birth should be given.



MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 1170 File No. 1  
Township Richmond Primary Registration District No. 6248 H Registered No. 10  
City Richmond St.        Ward       

2. FULL NAME

Margaret Burger  
(a) Residence. No.        St.        Ward         
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M.</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, <u>      </u> hrs. or <u>      </u> min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		

PARENTS	10. NAME OF FATHER
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 4/5 19 28 Co. L. Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10 19 28

17. I HEREBY CERTIFY, That I attended deceased from       , 1928, to       , 1928, that I last saw h.        ago on       , 1928, and that death occurred, on the date stated above, at        m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Acute Respiratory failure  
Glioma, metastatic  
proliferant, but not cancer. (duration) yrs. mos. ds.  
CONTRIBUTORY Metastatic Brain (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH         
DID AN OPERATION PRECEDE DEATH        DATE OF         
WAS THERE AN AUTOPSY?         
WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) James Blaney, M. D.  
      , 19        (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

Every item of information should be carefully supplied. AGE should be correctly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-2499