5 1939

REC'D MAY 11 1939

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

16221
Do not use this space.

1. PLACE OF DEATH
(a) County St. Louis Registration District No. 784
(b) Township Clayton Distr. Primary Registration District No. 200 Registered No. 741
(c) City 2 (d) Street No. Link Road., Clayton, Mo. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME F.B. Berglar
(a) Residence, No. Link Rd., Clayton, Mo. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
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 Anna Berglar

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 12, 1855

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
84	0	10	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri 0

FATHER
13. NAME Henry Berglar 6
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 6

MOTHER
15. MAIDEN NAME Margaret Lemkes
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Joseph Berglar Route #2 Clayton, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cem. DATE Apr. 26 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jos. W. Clark 1125 Hodiamont Ave.

20. FILED APR 25 1939 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/22/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 9/4/38, 19, to 4/22/39, 19
I last saw him alive on 4/22/39, 19 Death is said to have occurred on the date stated above, at 11:15 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chr. Cardio-Vascular-Renal-disease.	?
131	
Uremia.	6 mo.
Uremic coma.	1 wk.
Myocardial insufficiency and collapse.	6 mo.
	1 wk.
Extreme senility-senile dementia.	6 mo.

Other contributory causes of importance:
Name of operation None Date of
What test confirmed diagnosis? History Was there an autopsy? No.
Clinical and Lab.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? -- (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. --
Manner of injury --
Nature of injury --

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify
(Signed) [signature] M. D.
(Address) 3718 Jennings Road.

Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sta[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importan[illegible]

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed Jas. N. Clark

Licensed Embalmer No. 1661

P. O. Address 1125 Hodiamont

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

162221
Do not use this space.

1. PLACE OF DEATH
(a) County: St Louis — Registration District No.: 784
(b) Township: Central — Primary Registration District No.: 200 — Registered No.: 741
(c) City: — (d) Street No.: St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: FRANCIS BERNARD Berglar
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE: Years 84 — Months 0 — Days 10 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE ,19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ....., 19.....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/22, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Luke B. Tiernon, M. D.
(Address) 3718 Fenning Rd.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUN 14 1939