

JUL 12 1939

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

20723  
Do not use this space.

791  
1003

1. PLACE OF DEATH  
 (a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. .... Registered No. **5567**  
 (c) City St. Louis, Mo. (d) Street No. BARNES HOSPITAL 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. 8 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME GOLNE HELEN BERGSTRÖM  
 (a) Residence, No. .... St. WR CHENEYVILLE, ILL  
 (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 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 Walter B. Bergstrom  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 30, 1898  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
41 5 1  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife.  
 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) Harrisonberg Virginia  
 FATHER 13. NAME John Lawson  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harrisonberg Virginia  
 MOTHER 15. MAIDEN NAME Emma Boyers  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harrisonberg Virginia  
 17. INFORMANT (ADDRESS) Dorothy Helen Bergstrom Cheneyville, Illinois  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Hoopston, Ill DATE June 24, 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hamilton Funeral Hs. Hoopston, Ill.  
 20. FILED JUN 23 1939 J. D. Baudek Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-21-1939  
 22. I HEREBY CERTIFY, That I attended deceased from 6-13-1939 to 6-21-1939  
 I last saw her alive on 6-21-1939 Death is said to have occurred on the date stated above, at 5:10 p.m.  
 The principal cause of death and related causes of importance were as follows:  
LIPOMA OF MEDIASTINUM  
(PULMONARY EMBOLISM) Date of onset 6-21-39  
Benign tumor  
 Other contributory causes of importance: 54e  
 Name of operation REMOVAL LIPOMA Date of 6-20-39  
 What test confirmed diagnosis: X-RAY Was there an autopsy? YES  
 OPERATION  
 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) Henry Hoffner BARNES HOSPITAL, M. D.  
 (Address) \_\_\_\_\_

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.

**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

*Arnold W. Schoene*

Licensed Embalmer No.

*3864*

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