WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27637

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3271

1. PLACE OF DEATH:

(a) County Jackson County

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Little Sisters of the Poor 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 8 months
years, months or days) Otto Bergenhofer

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County JACKSON

(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 5331 HIGHLAND
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 60 years.

3. (a) PRINT FULL NAME Otto Bergerhofer 1.25

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex M

5. Color or race White

6. (a) ~~Single, widowed~~, married, ~~divorced~~ Married

6. (b) Name of husband or wife Dora Hografe

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased June (Month) 30th (Day) 1962 (Year)

8. AGE: Years 78 | Months 1 | Days 15 | If less than one day ___ hr. ___ min.

9. Birthplace Germany (City, town, or county) 6 (State or foreign country)

10. Usual occupation None

11. Industry or business —

FATHER
12. Name John Bergerhofer
13. Birthplace Germany (City, town, or county) 6 (State or foreign country)

MOTHER
14. Maiden name Francisca Sprote
15. Birthplace — (City, town, or county) 9 (State or foreign country)

16. (a) Informant Sister Camille
(b) Address 5331 Highland Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-40 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Calvary

18. (a) Signature of funeral director Quirk & Tobin Co
(b) Address K.C. Mo.

19. (a) Aug. 19, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 16th year 1940 hour 12 minute 45 A. M.

21. I hereby certify that I attended the deceased from July 11, 1940 to Aug 15, 1940 that I last saw him alive on Aug 7, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion	30 Min
Due to arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations none	
Of autopsy none	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature John T. Skinner (M. D. or other) MD
Address 1402 Bryant Bldg Date signed 8-17-40
K.C. MO

(Licensed Embalmer's Statement on Reverse Side)

1401 Bryant Bldg.
Dr. John T. Atkins

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 Maurice A. Lynch

Licensed Embalmer No. 3634

P. O. Address 20 W Lenwood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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