

No. 2
p. 43
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37823

FILED MAR 31 1947

Registration District No. _____

Primary Registration District No. **4318**

Registrar's No. **16**

1. PLACE OF DEATH: Maries

(a) County **Vienna, Mo.**

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

(c) Name of hospital or institution: **/**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community **15 Years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Maries**

(c) City or town **Vienna, Mo.**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINTED FULL NAME: Armon Fredrich Wilhelm Berghorn

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Genova Berghorn** 6. (c) Age of husband or wife if alive **30** years

7. Birth date of deceased **Aug. 17 1897**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **4th**
year **1947** hour **10** minute **10** A.M.

21. I hereby certify that I attended the deceased from **January 13**, 19**47**, to **March 4**, 19**47**;
that I last saw him alive on **March 4**, 19**47**;
and that death occurred on the date and hour stated above.

8. AGE:	Years 49	Months 6	Days 17	If less than one day hr. _____ min. _____
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Immediate cause of death **Pneumonia** **1 week**

Due to **Paralysis of intercostal muscles of respiration** **5 Mo.**

Due to **Extradural abscess of cord** **5 Mo.**

Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace **Union, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Merchant**

11. Industry or business _____

Major findings: Of operations _____ Of autopsy _____

PHYSICIAN _____

Underline the cause to which death is attributed. ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

MOTHER FATHER

12. Name **Edward Berghorn**

13. Birthplace **Franklin County, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Louise Kruel**

15. Birthplace **Franklin County, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Genova Berghorn**
(b) Address **Vienna, Mo.**

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? _____

While at work? _____ (Specify type of place) (c) Means of injury **2**

23. Signature **S. C. Howard** (M. D. or other) **D.O.**
Address **Vienna, Missouri** Date signed **3/17/47**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3-7-1947**
(Month) (Day) (Year)

(c) Place: burial or cremation **Vienna, Mo.**

18. (a) Signature of funeral director **M. C. Cunningham**
(b) Address **Vienna, Mo.**

19. (a) **3-16-47** (Date received local registrar) (b) **Pauline Howard** (Registrar's signature)

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

Date Filed 3/28/47
District File Number _____

District Health Officer No. 9,

RECEIVED

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 W. O. Birmingham

Licensed Embalmer No. 3664

P. O. Address: Vienna, Va.

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, fact should be so stated above.

Registration District No. 207

Primary Registration District No. 4318

1. PLACE OF DEATH:

(a) County Maries
(b) City or town Merina
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____ (Specify whether
In this community _____ years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Amos F. W. Berghon

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color of race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased aug 17 1891
(Month) (Day) (Year)

8. AGE: Years 49 Months 6 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death Bronchial pneumonia Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

9943