

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4691**

FILED FEB 25 1952

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5465** Registrar's No. **150**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY GREENE	
b. CITY OR TOWN Springfield, Rural North Campbell Twp		c. CITY OR TOWN Springfield, North Campbell Twp RURAL	
c. LENGTH OF STAY (in this place) 4 yrs		d. STREET ADDRESS (If rural, give location) 0370 SPRINGFIELD MO. R.F.D. 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION RR # 2			

3. NAME OF DECEASED (Type or Print)	a. (First) ANNA	b. (Middle) ED NA	c. (Last) BERGLUND	4. DATE OF DEATH (Month) (Day) (Year)
				2-17-52

5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 6-11-1876	9. AGE (In years last birthday) 75	10. UNDER 1 YEAR 8	11. UNDER 1 MONTH 6	12. UNDER 1 HOUR 6
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE	11. BIRTHPLACE (State or foreign country) GREEN CO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME BRADFORD NORRBY	13b. MOTHER'S MAIDEN NAME VICTORY MOPPIN	14. NAME OF HUSBAND OR WIFE JOHN F.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME JOHN F. BERGLUND	R.F.D. ADDRESS SPRINGFIELD MO
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma - Head of the Pancreas		8 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Obstruction of the common duct		4 hrs
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		157X

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov 29, 1947**, to **Feb 17, 1952**, that I last saw the deceased alive on **Feb 14, 1952**, and that death occurred at **7:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE John W. ... M.D.	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 2-19-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 2-19-52	24c. NAME OF CEMETERY OR CREMATORY EAST LAWN	24d. LOCATION (City, town, or county) (State) S PRINGFIELD MO
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DATE REC'D BY LOCAL REG. 2-19-52	REGISTRAR'S SIGNATURE James Ramos, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Kelly Farrell-Bergman	ADDRESS Seymour MO
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(Licensed Embalmer's Statement on Reverse Side)

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

No. will be 0390

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Don G. Ferrell* _____

Licensed Embalmer No. *4847* _____

P. O. Address *Mansfield, 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, fact should be so stated above.