

FILED AUG 6 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24259

318

1003

Registrar's No. 7094

BIRTH MO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 24259	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (In this place) 85 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		2158	
d. FULL NAME OF (If in hospital or institution, give street address) HOSPITAL OR INSTITUTION HOME OF THE FRIENDLESS				d. STREET ADDRESS (If rural, give location) 15 4431 So. Broadway			
3. NAME OF DECEASED a. (First) MINNIE (WILHELMINA) (Type or Print)			b. (Middle) _____		c. (Last) BERG		4. DATE OF DEATH (Month) (Day) (Year) July 29, 1954
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH June 24, 1869		9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) resident		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Frederick Cordes			13b. MOTHER'S MAIDEN NAME Bernadina Straetker		14. NAME OF HUSBAND OR WIFE Frederick J. Berg		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Adolph A. Jacobs, 908 Poplar Dr.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH 6 mo	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Liver & Pancreas (Carcinoma)	ANTECEDENT CAUSES (Carcinoma)					DUE TO (b) _____	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS - Fracture left femur fell in her room 3/15/54	Conditions contributing to the death but not related to the disease or condition causing death.					Interval between onset and death 6 mo	
19a. DATE OF OPERATION no	19b. MAJOR FINDINGS OF OPERATION no					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1561 F					
22. I hereby certify that I attended the deceased from 4/9, 1954 , to 7/29, 1954 , that I last saw the deceased alive on 7/28, 1954 , and that death occurred at 2:32 PM , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Chris E. Heydman MD				23b. ADDRESS 3720 Washington		23c. DATE SIGNED 7/31/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE Aug. 2, 1954	24c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		
DATE REC'D BY LOCAL REG. JUL 31 1954		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Beiderwieden F.H. Inc., 1936 St. Louis Ave.			

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

Dr. Hundman
3720 Washington Av.
11-1

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 _____

Licensed Embalmer No. 4520

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, fact should be so stated above.