

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008972  
STATE FILE NUMBER

FILED MAR 30 1959

Registration District No. 115-116 Primary Registration District No. 3030 Registrar's No. 74

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>0920</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis</u>		Length of stay in lb <u>1 day</u>	d. STREET ADDRESS (If outside, give location) <u>RR. Augusta Mo</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN F. BERGSIEMER</u>			4. DATE OF DEATH Month Day Year <u>3 - 12 59</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30-1887</u>
9. AGE (In years last birthday) <u>71</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Schleusburg Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Schleusburg Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>L. Bergsiek</u>		13b. MOTHER'S MAIDEN NAME <u>K. Noelke</u>	14. NAME OF HUSBAND OR WIFE <u>Edna Bergsiek</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>493-42-5009</u>	17. INFORMANT Address <u>Vernon Bergsiek Augusta Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) <u>coronary occlusion</u>			<u>6 wks</u>
DUE TO (c) <u>Previous myocardial infarction</u>			<u>1 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>January 1959</u> to <u>Mar 12 1959</u> and last saw him alive on <u>Mar 12th. 1959</u> Death occurred at <u>St. Francis Hospital</u> at <u>10P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. Schmidt M.D.</u>		22b. ADDRESS <u>Marshallville Mo</u>	22c. DATE SIGNED <u>3-14-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/15/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Schleusburg</u>	23d. LOCATION (City, town, or county) (State) <u>A. B. Augusta Mo</u>
24. FUNERAL DIRECTOR <u>Olie Thieling</u>		25. DATE RECD. BY LOCAL REG. <u>3/23/59</u>	26. REGISTRAR'S SIGNATURE <u>W. J. Sidman &amp; J. C. Sidman</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 .....  
Signature of Student Embalmer

Signed *Harward O Kessler* .....

Licensed Embalmer No. *4631* .....

P. O. Address *Wentzville* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.