

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042760

FILED VS. NOV 30 1959 317

Primary Registration District No. **531**

Registrar's No. **2979**

STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY ST Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits use TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| Length of stay in 1b MINS. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF DECEASED HOSPITAL OR INSTITUTION Christian Old Peoples | | d. STREET ADDRESS (If outside, give location) 5016 Devonshire | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First William Middle H. Last Bergman | | | 4. DATE OF DEATH Month Nov. Day 8, Year 1959 | | |
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|-----------------------|----------------------------------|---|---|---|---|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 19, 1866 93 | 9. AGE (last birthday) IF UNDER 1 YEAR Months 0 Days 19 Hours Min. | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY Self Employed | 11. BIRTHPLACE (City and state or country) Columbia, Ill | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Joseph Bergman | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE unk. |
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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. None | 17. INFORMANT Arthur Bergman Address 5016 Devonshire |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiac Failure | | 2 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | Many years |
| DUE TO (b) Chronic Myocarditis | | |
| DUE TO (c) Arteriosclerotic Heart Disease | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0 | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) |
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| 20c. TIME OF INJURY Hour s.m. p.m. | Month, Day, Year |
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|--|--|---|---------------------------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT 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 Columbia | COUNTY Illinois | STATE |
|--|--|---|---------------------------|-------|

21. I attended the deceased from **1925** to **Nov. 8, 1959** and last saw him alive on **Nov. 7, 1959**
Death occurred at **5:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE James Schumacher M.D. (Degree or title) | 22b. ADDRESS 3701 Grand St. | 22c. DATE SIGNED 11/9/59 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Nov. 10, 1959 | 23c. NAME OF CEMETERY OR CREMATORY St. Pauls Evan. Cem. | 23d. LOCATION (City, town, or county) Columbia, Illinois |
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| 24. FUNERAL DIRECTOR Schumacher's ADDRESS 3013 Meramec St. | 25. DATE RECD. BY LOCAL REG. 11-9-59 | 26. REGISTRAR'S SIGNATURE Jahn C. Murphy M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

was for ...
for call on District
Community Test Administrator

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 Jack Haupt

Licensed Embalmer No. 4746

P. O. Address St Louis

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.