

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-80-043021

FILED VS. NOV 28 1960

274

Registration District No. 3052

Registrar's No. 393

STATE FILE NUMBER

DED

|   |  |   |  |  |  |  |   |
|---|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  |  |  |   |
| a. COUNTY <u>Pettis</u>   |  | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>                          |  | a. STATE <u>Mo</u>   |  | b. COUNTY <u>Pettis</u>  |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>602 E. 11th</u>  |  | Length of stay in 1b <u>66 yrs</u>  |  | c. CITY OR TOWN <u>Sedalia</u>   |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
|   |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                         |  | d. STREET ADDRESS (If outside, give location) <u>611 East 9th</u>  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Gustave August Bergfelder</u>  |  |   |  | 4. DATE OF DEATH Month Day Year <u>Nov 22 1960</u>   |  |  |   |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>   |  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>1-19-1888</u>  |   |
|   |  |   |  | 9. AGE (last birthday) <u>77</u>   |  | IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.                              |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber foreman</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Pub. Service</u>   |  | 11. BIRTHPLACE (City and state or country) <u>California Mo</u>  |  | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>   |   |
| 13a. FATHER'S NAME <u>Wm Henry Bergfelder</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>Sophia Meyer</u>   |  | 14. NAME OF HUSBAND OR WIFE <u>Olive A. Shope</u>  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  | 16. SOCIAL SECURITY NO. <u>491-07-4342</u>  |  | 17. INFORMANT <u>Mrs Walter Russell</u> Address <u>602 E. 11th Sedalia</u>   |  |  |   |
| 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 <u>24 hrs</u>  |
| IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>  |  |   |  |  |  |  |   |
| DUE TO (b) <u>P.S.H.D.</u>  |  |   |  |  |  |  |   |
| DUE TO (c) _____  |  |   |  |  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma prostate</u> |  |   |  |  |  |  | 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 |
| 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 a.m. p.m. Month, Day, Year   |  |   |  |  |  |  |   |
| 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   |  | COUNTY STATE   |   |
| 21. I attended the deceased from <u>1952</u> to <u>11-22-60</u> and last saw <u>her</u> him alive on <u>11-8-60</u>   |  |   |  |  |  |  |   |
| Death occurred at <u>8 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |  |  |  |   |
| 22a. SIGNATURE (Degree or title) <u>Oliver L. Lowe M.D.</u>   |  |   |  | 22b. ADDRESS <u>Sedalia Mo</u>   |  | 22c. DATE SIGNED <u>11-22-60</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE <u>11-25-1960</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>  |  | 23d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>                    |   |
| 24. FUNERAL DIRECTOR <u>McLaughlin Bros</u> ADDRESS <u>Sedalia</u>  |  |   |  | 25. DATE RECD. BY LOCAL REG. <u>11-24-1960</u>   |  | 26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>                                    |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 5 1960

JUN 4 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed K.P.M. Crav

Licensed Embalmer No. 3153

P. O. Address Sedalia

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.