

PA 7-0610

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041874

STATE FILE NUMBER

FILED NOV 20 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10809

300  
-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		Length of stay in lb <b>D.O.A.</b>	d. STREET ADDRESS (If outside, give location) <b>3401a N. Florissant</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Margaret Lindo</b>			4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-23-1890</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Mount Olive, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Thomas Thompsen</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth</b>		14. NAME OF HUSBAND OR WIFE <b>Emil Lindo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Emil Lindo, 3401a N. Florissant Ave.,</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)					332X
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus</b>					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 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 <b>June 1950</b> to <b>Nov 9 '58</b> and last saw her/him alive on <b>Nov 8 1958</b> Death occurred at <b>9:00 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Parusbaum MD</b> (Degree or title)			22b. ADDRESS <b>3701 Grandel St</b>		22c. DATE SIGNED <b>11-10-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11-9-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olive Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mount Olive, Illinois.</b>
24. FUNERAL DIRECTOR <b>Math. Hermann &amp; Son Inc. 2161 E. Fair Ave.</b>			25. DATE RECD. BY LOCAL REG. <b>NOV 10 58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	

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 *Alvin W. Hays* .....

Licensed Embalmer No. *3757* .....

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.