

REC'D JUN 8 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

18658  
Do not use this space.

## 1. PLACE OF DEATH

(a) County GREENE Registration District No. 318  
(b) Township Campbell Primary Registration District No. 2001 Registered No. 431  
(c) City SPRINGFIELD (d) Street No. 1420 E. Sunshine St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

AUGUST FREDICK LINDHORST  
(a) Residence, No. 1420 E. Sunshine St.  (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 3 - 1863  
7. AGE, YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
76 4 20  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time spent in this occupation  
Retired Gardener  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo  
13. NAME Herman Lindhorst  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany  
15. MAIDEN NAME Caroline L. Ackersol  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany  
17. INFORMANT (ADDRESS) Edda Lindhorst  
1420 E. Sunshine  
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE May 26, 1939  
Hazelwood  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wann Hall  
Springfield Mo  
20. FILED 5-26-1939 Chas. George Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 24, 1939  
22. I HEREBY CERTIFY, That I attended deceased from May 11, 1939 to 5-24-39  
I last saw him alive on May 17, 1939. Death is said to have occurred on the date stated above, at 2:10 p.m.  
The principal cause of death and related causes of importance were as follows:

Anterosclerosis  
Chronic myocardial failure  
Other contributory causes of importance:  
Date of onset 1935  
May

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) Robert Glynn, M. D.  
(Address) Springfield

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Rayd W. Ford*

Licensed Embalmer No. *2910*

P. O. Address *629 W Walnut*

**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, above space should be left blank.**