U. S. No. 2
M—11-10-39
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10276

FILED APR 12 1940

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 357

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1½ Hours. (Specify whether
In this community 32 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits write "RURAL")
(d) Street No. 1212 N. 3Rd
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Theodore Lund 530
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race wht.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lena Lund
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Do Not Know (Month) (Day) (Year)

8. AGE: Years Est. 56 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Wilna (City, town, or county) Lithunia (State or foreign country)
10. Usual occupation Retired
11. Industry or business
FATHER
12. Name Max Lund
13. Birthplace Wilna (City, town, or county) Lithunia (State or foreign country)
MOTHER
14. Maiden name Mamie Levatas
15. Birthplace Wilna (City, town, or county) Lithunia (State or foreign country)
16. (a) Informant Max Lund
(b) Address 113 N. 5th St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 31, 40 (Month) (Day) (Year)
(c) Place: burial or cremation Shaare Sholum
18. (a) Signature of funeral director FLEEMAN & SON, INC.
(b) Address St. Joseph, Mo.
19. (a) 4/1/40 (Date received local registrar) (b) H. Mastlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 29th
year 1940 hour 9 minute 30 A.M.
21. I hereby certify that I attended the deceased from Mar 29, 1940, to Mar 29, 1940
that I last saw him alive on Mar 29, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	Mar 24/40
Due to 94	
Due to	
Other conditions Edema of lungs (Include pregnancy within 3 months of death)	Mar 25/40

Major findings:
Of operations ✓
Of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Frank [illegible] (M. D. or other)
Address [illegible] Date signed Mar 30/40

(Licensed Embalmer's Statement on Reverse Side)

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 C. G. Swan

Licensed Embalmer No. 4082

P. O. Address St Joseph

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.