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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

DEC 10 1941

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 1063

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(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 5 days (Specify whether  
In this community Lifetime years, months or days)

3. (a) PRINT FULL NAME Katherine Lundon

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: May 20 1875  
(Month) (Day) (Year)

8. AGE: Years 66 Months 5 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: St. Joseph Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business At Home

12. Name Unknown

13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Herzog

(b) Address 1015 Faraon St. St. Joseph, Mo.

17. (a) Burial (b) Date thereof Nov. 8, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Harold W. Sidenfader  
(b) Address 1802 Union Spr. St. Joseph, Mo.

19. (a) 11-7-41 (b) H. Hestlebusch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11  
(c) City or town St. Joseph 1  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2024 Julie St. 7  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 6th  
year 1941 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from October 24 to Nov 6 1941  
that I last saw her alive on Nov 5 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial infarctus Duration 2 wks.

Due to: Arterio-sclerosis & Hypertrophy of heart ?  
Due to: \_\_\_\_\_ ?

Other conditions: Paralysis agitans 10 yrs.  
(Include pregnancy within 3 months of death)

Major findings: None 4MC PHYSICIAN  
Of operations \_\_\_\_\_  
Of autopsy: None  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature M. H. Talbot (M. D. or other) MD  
Address Conly Bldg. St. Joseph, Mo. Date signed 11/6/41

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

MOTHER FATHER

APR 15 1954

**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 me

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

Signed Albert R. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo

**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, fact should be so stated above.**