17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN -5 1942

Registration District No. 290

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5983

State File No. 41651

Registrar's No. ~~35~~ 131

1. PLACE OF DEATH:

(a) County: Pulaski

(b) City or town: Fort Leonard Wood, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Cattleman Hospital
Fort Leonard Wood, Missouri
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution - - - (Specify whether
In this community 4 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Minnesota (b) County: Meeker 999

(c) City or town: Cosmos 21
(If outside city or town limits, write "RURAL")

(d) Street No. - - - 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME: LESTER G. GUNDERSON (Pvt)

3. (b) If veteran, name war - - -

3. (c) Social Security No. - - -

4. Sex: Male 0

5. Color or race: White

6. (a) Single, widowed, married, divorced: 0 Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: October (Month) 7 (Day) 1900 (Year)

8. AGE:

Years	Months	Days	If less than one day
42	2	0	hr. min.

9. Birthplace: Cosmos (City, town, or county) Minnesota 1 (State or foreign country)

10. Usual occupation: Soldier-U.S.Army-37308024

11. Industry or business: 3478 Ordnance Co. 85th Ord Bn.

FATHER
12. Name: Unknown
13. Birthplace: Unknown 9 (City, town, or county) - - - (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown 9 (City, town, or county) - - - (State or foreign country)

16. (a) Informant: U. S. Army Records
(b) Address: Fort Leonard Wood, Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director: S. C. Nuell
(b) Address: Rolla Funeral Home

19. (a) 12/8/42 (Date received local registrar) (b) T. B. Faulmeyer (Registrar's signature)

12-14-1942 Chas M. O. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 7
year 1942 hour 2 minute 00 P.M.

21. I hereby certify that I attended the deceased from - - -
, 19 , to - - - , 19 ;
that I last saw h alive on - - - , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death: (1) Thrombosis, right coronary artery due to arteriosclerosis, (advanced). (2) Fibrosis, hypertrophy and dilatition of heart.

Due to

Due to

Other conditions 94a
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy: As above

Duration

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: Miles E. Foster Jr. Capt. M.C. (M. D. or other) M.D.
Address: Station Hosp. Ft. L. Wood, Mo. Date signed 12/8/42

(Licensed Embalmer's Statement on Reverse Side)

4

RECEIVED
Pulaski County Health Officer
File Number 12-42-216
Date Filed 12-31-42

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 S. C. Nyce

Licensed Embalmer No. 3397

P. O. Address Rolla Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
3-21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41651

Registration District No. 290 Primary Registration District No. 5983 Registrar's No. 131

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

1. PLACE OF DEATH:
(a) County: Pulaski
(b) City or town: Cullen Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Lester G. Gunderson (Pvt)
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Oct (Month) 7 (Day) 1890 (Year)
8. AGE: Years 42 Months 2 Days (If less than one day hr. min.
9. Birthplace: (City, town, or county) Minn (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-9-42 (Month) (Day) (Year)
(c) Place: burial or cremation (Fairfield Minn.)
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 7 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)
(b) 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

41651