

WORLD WAR 6/28/43  
418

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6355  
Registrar's No. 98

Registration District No. 2000

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
O'Reilly General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 91 days  
(Specify whether  
In this community 91 days  
years, months or days)

3. (a) PRINT FULL NAME RAOUL G. LINDHE

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

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

6. (b) Name of husband or wife None  
6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased September 24, 1915  
(Month) (Day) (Year)

8. AGE: Years ✓ 27 Months 4 Days 7  
If less than one day hr. min.

9. Birthplace Stockholm Sweden  
(City, town, or county) (State or foreign country)

10. Usual occupation Reporter

11. Industry or business Newspaper

12. Name Ivan Lindhe

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

14. Maiden name Unknown

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

16. (a) Informant WJ, AGO Forms #20 and #24

(b) Address Springfield, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Missouri

18. (a) Signature of funeral director Alvin J. ...  
(b) Address Springfield, Mo.

19. (a) 2-3-43 (Date received local registrar) (b) W. J. Lindley (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County New York  
(c) City or town New York  
(If outside city or town limits, write "RURAL")  
(d) Street No. 151 E. 46th Street  
(If rural, give location)  
(e) Citizen of foreign country? Yes (Yes or No)  
If yes, name country Sweden 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 1  
year 1943 hour 11 minute 25 A. M.

21. I hereby certify that I attended the deceased from  
November 3, 1942 to February 1, 1943  
that I last saw him alive on February 1, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia, terminal  
Duration 2 wks

Due to Acute Nephritis 6 wks

Due to Periarteritis nodosa 9 mos.

Other conditions (Include pregnancy within 3 months of death) 99.2

Major findings: Of operations \_\_\_\_\_

Of autopsy Confirmation of above diagnoses.

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? \_\_\_\_\_

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

23. Signature W. J. Lindley (M.D. or other) \_\_\_\_\_  
Address 612 E. 46th St. N.Y.C. Date signed 2-2-43

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

MOTHER FATHER

39  
2  
6

991  
30

4

984

DEC 27 1949

---

---

**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 Harlow Knabb

Licensed Embalmer No. 4065

P. O. Address Springfield, 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.**