V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26901

Registration District No. 149 Primary Registration District No. 1002. Registrar's No. 3520

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

8
3
8

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Colonial Rest Home 4 7611 Wornall
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days (Specify whether

In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 18

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 4400 Troost Avenue 3
(If rural, give location)

(e) Citizen of foreign country? YES (Yes or No) 8

If yes, name country SWEDEN 0

3. (a) PRINT FULL NAME DR. BERNHARD WALDEMAR LINDBERG

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mrs. Laura Lindberg

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

7. Birth date of deceased September (Month) 15 (Day) 1866 (Year)

8. AGE: Years 77 Months 11 Days 10 If less than one day hr. min.

9. Birthplace Gothenberg (City, town, or county) Sweden 11 (State or foreign country)

10. Usual occupation M.D. & D.O.

11. Industry or business

FATHER
12. Name Unknown Lindberg
13. Birthplace " (City, town, or county) Sweden 4 (State or foreign country)

MOTHER
14. Maiden name Carlberg 11
15. Birthplace (City, town, or county) Sweden 4 (State or foreign country)

16. (a) Informant Mrs. Fannie Annette Holmgren

(b) Address 110th & Penn

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof AUGUST-29-1944 (Month) (Day) (Year)

(c) Place: burial or cremation D. W. Newcomer Sons

18. (a) Signature of funeral director D. W. Newcomer Sons

(b) Address 1401 Brush Creek Blvd

19. (a) 8-29-44 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month August day 26th year 1944 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from Aug 23, 1944 to Aug 26, 1944; that I last saw him alive on 8/26, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	2 days
Due to Chronic Bronchitis	
Due to	
Other conditions Anemia (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

10 7

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 [signature] (M. D. or Chief)

Address 4526 Wornall Date signed 8/28/44.

K.C. Mo.

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(Licensed Embalmer's Statement on Reverse Side)

7526 Harwell Road

MAY 5 1948

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 Oscar Toney

Licensed Embalmer No. 1767

P. O. Address KC 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.