

FILED JUL 13 1945

Registration District No. **13**

Primary Registration District No. **3003**

Registrar's No. **53**

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

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Monett
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Vincent Hospital **0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution May 24 to June 24
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 48
(c) City or town Kansas City **5**
(If outside city or town limits, write "RURAL") **8**
(d) Street No. 7440
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

John Lindquist

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 2 widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 25 1862
(Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days 29 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Alfred J. Lindquist

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

14. Maiden name Helina Johanna Dahl

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

16. (a) Informant Ljuda Ross

(b) Address Kansas City Mo

17. (a) Burial (b) Date thereof June 25-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springview Cem.

18. (a) Signature of funeral director Oscar J. Mars

(b) Address Kansas Mo

19. (a) June 25-45 (b) Audna Willoughby
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24
year 1945 hour 6 minute 13 A.M.

21. I hereby certify that I attended the deceased from April 15 to June 24, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Myocarditis **3 weeks**

Due to Streptococcus infection of right foot **3 mos**

Due to osteomyelitis of toes of toes and foot **1 year**

Other conditions: Sclerosis of arteries

Major findings: Of operations _____

Of autopsy None

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 0

23. Signature A. H. Ferguson M. D. or other MD
Address Monett Mo Date signed 6-24-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1520

RECEIVED

District Health Officer No. 6,

District File Number 245-773

Date Filed JUL 11 1945

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.....

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

Signed Orson L. Marsh.....

Licensed Embalmer No. 3812.....

P. O. Address Quora, 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.