

S. No. 2
DOM-5-43
Rev. 5-17-39
I X36871

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7674**
Registrar's No. **1616**

FILED MAR 1 1946
318

Registration District No. _____ Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
6624

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
3859a Wyoming
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 65 years years, months or days)

3. (a) PRINT FULL NAME William Lind

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 Married

6. (b) Name of husband or wife Hulda Lind 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased December 7, 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>65</u>	<u>2</u>	<u>7</u>	hr. _____ min.

9. Birthplace St. Louis County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Tavern Owner

11. Industry or business Self

MOTHER FATHER

12. Name Ernst Lind

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

14. Maiden name Margaret Feitz

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

16. (a) Informant Mrs. Hulda Lind

(b) Address 3859a Wyoming

17. (a) Burial (b) Date thereof 2/18/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Beidervieden F. H., Inc.

(b) Address 1936 St. Louis Avenue

19. (a) FEB 18 1946 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 1617

(d) Street No. 3859a Wyoming
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 14,
year 1946 hour 3: minute 10 P. M.

21. I hereby certify that I attended the deceased from 4-10, 1946 to 2-14, 1946
that I last saw him alive on 2-13, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis
arteriosclerosis

Duration 3 years
4 years

Due to _____

Due to _____

Other conditions 92
(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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work _____ (c) Means of injury _____

23. Signature W. Demko (M. D. or _____)
Address 3950 Grand Date signed 2/18/46

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.....

Glen W. Katz

Licensed Embalmer No.....

3737

P. O. Address.....

1936 St. Louis Ave

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.