

S. No. 2
 M-5-43
 7-5-17-39
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FILED JUL 26 1947
 128

State File No. _____
 Registrar's No. 617

Registration District No. _____ Primary Registration District No. 2000

1. PLACE OF DEATH: **GREENE**
 (a) County _____
 (b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1318 N. Grant Ave.
(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 **20 Years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Greene**
 (c) City or town **Springfield**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1318 N. Grant Ave.**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **ALVIN THEODORE LINDHOLM**
 3. (b) If veteran, name war **none** 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 **Edna Lindholm** 6. (c) Age of husband or wife if alive **38** years
 7. Birth date of deceased **January 14, 1905**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **July** day **11th**
 year **1947** hour **11:40 P.M.** minute _____ M.
 21. I hereby certify that I attended the deceased from **JUNE 26** to **JULY 11**, 19**47**
 that I last saw him alive on **JULY 9**, 19**47**
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	42	5	27	_____ hr. _____ min.

Immediate cause of death **SARCOMA - WITH MULTIPLE METASTASIS**
Primary in RIGHT Axillary Gland
 Due to _____
 Due to _____

9. Birthplace **Mt. Grove, Missouri**
(City, town, or county) (State or foreign country)
 10. Usual occupation **S.W. State College Custodian**

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

11. Industry or business **S.W. State (Missouri) College**
 12. Name **Charles T. Lindholm**
 13. Birthplace **Stockholm, Sweden**
(City, town, or county) (State or foreign country)
 14. Maiden name **Alma Linder**
 15. Birthplace **Stockholm, Sweden**
(City, town, or county) (State or foreign country)

Major findings: _____
 1. Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Edna Lindholm**
 (b) Address **1318 N. Grant Ave., Springfield, Mo.**
 17. (a) **Burial** (b) Date thereof **July 14, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Greenlawn Cemetery**

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?

18. (a) Signature of funeral director **Fred C. Thieme**
 (b) Address **Springfield, Missouri**
 19. (a) **7-16-47** (b) **W.E. Handley M.D.**
(Date received local registrar) (Registrar's signature)

While at work? _____
(Specify type of place)
 23. Signature **D. F. Yull** (M. D. or other) **DO**
 Address **Springfield, Mo.** Date signed **7/13/47**

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

39
2
6

39
2
6
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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.....

Ralph H. Thorne

Licensed Embalmer No. 3681

P. O. Address. Springfield, Missouri

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.