

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18322**
Registrar's No. **5227**

MAILED JUN 15 1951

BIRTH NO. **10599-51** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		6. STREET ADDRESS (If rural, give location) 5663 Ashland Ave.	
c. LENGTH OF STAY (In this place) 3-months		7. 2069	

3. NAME OF DECEASED (Type or Print) a. (First) Patrick b. (Middle) J. c. (Last) Lund	4. DATE OF DEATH (Month) (Day) (Year) June 7, 1951
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5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.	8. DATE OF BIRTH Feb. 23, 1951	9. AGE (In years last birthday) 3 IF UNDER 1 YEAR Months 14 IF UNDER 12 HRS. Hours 14 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) III	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U
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13a. FATHER'S NAME George Lund	13b. MOTHER'S MAIDEN NAME Edwina Long	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mr. George Lund, 5663 Ashland Ave.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 mo
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial pneumonia ANTECEDENT CAUSES Hydrocephalus Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 752X
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22. I hereby certify that I attended the deceased from **6-4-51**, 19___, to **6-7-51**, 19___, that I last saw the deceased alive on ___ 19___, and that death occurred on **2** m., from the causes and on the date stated above.

23a. SIGNATURE E.H. Bowdler M.D.	(Degree or title)	23b. ADDRESS 634 N. Grand	23c. DATE SIGNED 6-7-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 7, 1951	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JUN 7 1951	REGISTRAR'S SIGNATURE J. B. Lester	25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly	ADDRESS 840 Lindell Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.