

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8859

State File No. ....

FILED MAR 23 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 323

1117  
22

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

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).															
a. COUNTY <u>Buchanan</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Jackson</u>													
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>54-27 16 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Independence 7605</u>													
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital no 2</u>		d. STREET ADDRESS (If rural, give location) <u>County Home 1</u>															
<b>3. NAME OF DECEASED</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year)														
a. (First) <u>Gust</u>			b. (Middle) <u>Wind</u>														
c. (Last) <u>Wind</u>			Date <u>March 10, 1953</u>														
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <u>single</u>													
<b>8. DATE OF BIRTH</b> <u>Feb 26 1904</u>		<b>9. AGE</b> (In years last birthday) <u>49</u>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">IF UNDER 1 YEAR</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>0</u></td> <td><u>14</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 1 YEAR	IF UNDER 1 YEAR	IF UNDER 1 YEAR	Months	Days	Hours	Min.	<u>0</u>	<u>14</u>		
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Months	Days	Hours	Min.														
<u>0</u>	<u>14</u>																
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania 1</u>													
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13a. FATHER'S NAME</b> <u>Fred Lind</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>not given</u>													
<b>14. NAME OF HUSBAND OR WIFE</b> <u>none</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>													
<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Fred Lind</u>		<b>17. ADDRESS</b> <u>1111 Myrtle Eric, Pa.</u>															
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		<b>MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>											
		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Lobar Pneumonia</u>				<u>4 days</u>											
		<b>ANTECEDENT CAUSES</b>															
		<b>DUE TO (b)</b> <u>Chronic Myocarditis</u> <b>DUE TO (c)</b> _____ <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>															
		<b>II. OTHER SIGNIFICANT CONDITIONS</b>															
		<b>Conditions contributing to the death but not related to the disease or condition causing death.</b> <u>Schizophrenia Paranoid Type</u>															
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>490X</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>													
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>													
<b>22. I hereby certify that I attended the deceased from <u>March 1, 1953</u>, to <u>March 10, 1953</u>, that I last saw the deceased alive on <u>March 9, 1953</u>, and that death occurred at <u>4:20</u> a.m., from the causes and on the date stated above.</b>																	
<b>23a. SIGNATURE</b> <u>Forrest Thomas</u>		<b>23b. ADDRESS</b> <u>St Joseph Mo of State Hosp. 702</u>		<b>23c. DATE SIGNED</b> <u>3/10-53</u>													
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24b. DATE</b> <u>3-13-1953</u>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Osteopathic College</u>													
<b>24d. LOCATION</b> (City, town, or county) (State) <u>Kirksville, Mo.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Paul Kuff</u>															
<b>DATE REC'D BY LOCAL REG.</b> <u>Mar 14, 1953</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Dwight P. Balmat</u>		<b>ADDRESS</b> <u>St. Joseph, Mo.</u>													

Deputy Registrar/Embalmer's Statement on Reverse Side

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 .....

.....  
working under my personal supervision.

Signed.....  
Student Embalmer

Signed

Student Embalmer No. ....

Licensed Embalmer No. 3986

P. O. Address St. Joseph, 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.