

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 17 1953

318

1003

 State File No. **44338**
11674

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis,		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				e. STREET ADDRESS (If rural, give location) 4769 Virginia			
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) LEE c. (Last) LYNDSEY			4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 8, 1953				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 22, 1891		9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY City of St. Louis,		11. BIRTHPLACE (City and State or Foreign Country) Moselle, Missouri.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John Lindsey		13b. MOTHER'S MAIDEN NAME Nan Gibson		14. NAME OF HUSBAND OR WIFE Nellie Marie Lindsey.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No.		16. SOCIAL SECURITY NO. Nil		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Henry Caldwell 4769 Virginia.			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastric-intestinal Permeability from problems ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Myocardial infarction Conditions contributing to the death but not related to the disease or condition causing death. Digitalis intoxication INTERVAL BETWEEN ONSET AND DEATH _____					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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) _____		21f. HOW DID INJURY OCCUR? 545X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 12-5-53 , 19____, to 12-8-53 , 19____, that I last saw the deceased alive on 12-8-53 , 19____, and that death occurred at 11:40 AM. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. Sheehan, M.D.				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 12-8-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-9-53	24c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		24d. LOCATION (City, town, or county) (State) St. Clair, Mo.		
DATE REC'D BY LOCAL REG. DEC 10 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington.			

Dr. Sheehan said intopication by digitalis was not a contributory factor. Cause of hemorrhage area not determined
 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.....
Signature of Student Embalmer

Signed *W. Wilkinson*.....

Licensed Embalmer No. *3575*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.