

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27919

Registrar's No. 7092

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>7092</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>3 Yrs. 3 Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Chronic Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>13 5800 Arsenal St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Peter</u> b. (Middle) <u>Herman</u> c. (Last) <u>Lund</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 12, 1955</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>Div.</u>		8. DATE OF BIRTH <u>May 22, 1884</u>	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 MRS. Hours _____ Mins. _____		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Furniture</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Peter Lund</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret</u>		14. NAME OF HUSBAND OR WIFE <u>Emma Lee Jaspring</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>497-03-3381A</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>St. Louis, Chronic Hosp. 5800 Arsenal</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CEREBRAL VASCULAR ACCIDENT</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>TERMINAL PNEUMONIA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 MON.</u> <u>YRS</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		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 _____					
22. I hereby certify that I attended the deceased from <u>5-16-52</u> , 19 <u>8+12-55</u> , 19____, that I last saw the deceased alive on <u>8-12-55</u> , 19____, and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>George M. Jenks, M.D.</u>				23b. ADDRESS <u>5800 Arsenal St.</u>		23c. DATE SIGNED <u>8/12/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8-12-55</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Nashville, Illinois</u>	
DATE REC'D BY LOCAL REG. <u>AUG 13 1955</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington.</u>			

S.D. (Licensed Embalmer's Statement on Reverse Side)

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..... *G. W. Wilkinson*

Licensed Embalmer No. *35*

P. O. Address *17 Len*

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.