

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11587  
STATE FILE NUMBER

FILED MAR 29 1957

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 659

Health, & Welfare  
Public Health Service  
S. 300  
v. 1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
193-140 MOBS 1949  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR <b>Berkeley City</b> <b>400</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Berkeley City</b> <b>4201</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Edgewood Retreat #4201 McKibbin Rd,</b> Length of stay in 1b <b>4 1/2 year</b>		d. STREET ADDRESS (If outside, give location) <b>4201 McKibbin Road</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Leathan</b> Last <b>Lund</b>			4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Pres, St. Louis</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>College Pharmacy.</b>	11. BIRTHPLACE (City and state or country) <b>Bowling Green Kentucky.</b>
13. FATHER'S NAME <b>Harry Majendie Lund.</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Stephenson.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Austin P. Leland #6443 Wydown Bl'vd,</b> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis, general.</b> DUE TO (c) <b>Senile changes general.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4201</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY: Hour, Month, Day, Year, a. m., p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>May 1940</b> to <b>3/7/57</b> and last saw her/him alive on <b>3/7/57</b> . Death occurred at <b>5:40 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Chas. N. Duden MD</b>		22b. ADDRESS <b>3720 Washington</b>	22c. DATE SIGNED <b>3.9.57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>3/11/1957.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory.</b>	23d. LOCATION (City, town, or county) (State) <b>#7800 St. Charles Road.</b>
24. FUNERAL DIRECTOR ADDRESS <b>C.R. Lupton and Sons 7233 Delmar Bl'vd.</b>		25. DATE RECD. BY LOCAL REG. <b>3/11/57</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Dombke MR</b>

(Licensed Embalmer's Statement on Reverse Side)

17.

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.