

FILED MAR 24 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008933

STATE FILE NUMBER

1 0 0 0

3 1 0

Registration District No. 4 2

Primary Registration District No.

Registrar's No.

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57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1006 Lincoln St.		d. STREET ADDRESS (If outside, give location) 1006 Lincoln St.	
3. NAME OF DECEASED (Type or print) First Middle Last Louisa T. Lindgren		4. DATE OF DEATH Month Day Year March 20, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Sweden
13a. FATHER'S NAME Not known		13b. MOTHER'S MAIDEN NAME Not known	14. NAME OF HUSBAND OR WIFE Gustav Lindgren
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Sophia Sams 426 E. Mo. Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastrointestinal Hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Cause undetermined</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <i>Generalized Arteriosclerosis</i>			
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.) 2	
20c. TIME OF INJURY Hour Month, Day, Year p.m. a.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 <i>3-13-58</i> to <i>3-20-58</i> and last saw her alive on <i>3-20-58 1:00 A.M.</i> Death occurred at <i>4:30 a</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Max C. Teare, M.D.</i>		22b. ADDRESS <i>732 1/2 Francis St.</i>	
		22c. DATE SIGNED <i>3-20-58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Mar. 22, 1958</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Odd Fellows Public Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Joseph Missouri</i>	
24. FUNERAL DIRECTOR <i>Clark Clark</i>		25. DATE RECD. BY LOCAL REG. <i>Mar. 21, 1958</i>	
ADDRESS <i>Clark Funeral Home St. Joseph, Mo.</i>		26. REGISTRAR'S SIGNATURE <i>Max Clark Stull</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Emma Clark*

Licensed Embalmer No. *4238*

P. O. Address *St. Joseph*

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.