Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003209
STATE FILE NUMBER

FILED JAN 26 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 26

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Montana b. COUNTY Missoula

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St.Louis — Inside Limits Yes [X] No [ ]

c. CITY OR TOWN Missourla — Inside Limits Yes [X] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St.John's Hospital — Length of stay in 1b 2 hrs.

825 d. STREET ADDRESS (If outside, give location) 417 Rollins — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Lindquist

4. DATE OF DEATH Month Day Year January 2, 1959

5. SEX Female

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]

8. DATE OF BIRTH June 30,1893

9. AGE (In years last birthday) 65 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseork

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (City and state or country) Mayfield,Mo. 0

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Kirby I.Smith

13b. MOTHER'S MAIDEN NAME Mary A.Grindstaff

14. NAME OF HUSBAND OR WIFE Eric Lindquist

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Mary A.Smith, Address 5916 Highfield Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 10 hrs.
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last — DUE TO (b) Hypertension & Arteriosclerosis
DUE TO (c) 331+
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [✓] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 1:00 AM 1-2-59, to End and last saw her/him alive on 1-2-59
Death occurred at 3:15 AM. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William A. Turner MD

22b. ADDRESS 4401 Hampton

22c. DATE SIGNED 1-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 1-2-59

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State) Missoula,Montana

24. FUNERAL DIRECTOR Albert H.Hoppe, ADDRESS 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG. JAN 2 59

26. REGISTRAR'S SIGNATURE J Earl Smith MD (H.T.)

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 .....

Licensed Embalmer No. .....

P. O. Address .....