

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-028345**

STATE FILE NUMBER

FILED VS SEP 15 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 234

1. PLACE OF DEATH a. COUNTY <u>Callaway Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Saline Co.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton, Missouri</u>		c. CITY OR TOWN <u>Malta Bend, Mo</u>	
Length of stay in 1b <u>41 Yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 1</u>		d. STREET ADDRESS (If outside, give location) <u>no street mo</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>J.</u> Last <u>Lunbeck</u>			4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-89</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanic</u>	11. BIRTHPLACE (City and state or country) <u>Vichey, Mo Maries</u>	12. CITIZEN OF WHAT COUNTRY <u>Saline C</u>
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13a. FATHER'S NAME <u>Rev. Oscar Lunbeck</u>	13b. MOTHER'S MAIDEN NAME <u>Francis Motley</u>	14. NAME OF HUSBAND OR WIFE <u>never married</u>
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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>Unknown</u>	17. INFORMANT <u>John Lunbeck</u> Address <u>Malta Bend, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Pneumonia</u>		<u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Fracture of the right femur</u>	<u>3 wks</u>
	DUE TO (c) <u>Arteriosclerotic heart disease</u>	<u>unknown</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw <sup>her</sup>him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Wm. J. Cremer</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>State Hosp - Fulton</u>	22c. DATE SIGNED <u>9-7-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>19 Sept 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Malta Bend Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Malta Bend Missouri</u>
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24. FUNERAL DIRECTOR <u>Wallace Funeral Home</u> ADDRESS <u>Fulton, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 7-1959</u>	26. REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>
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DOCUMENT

MEDICAL CERTIFICATION

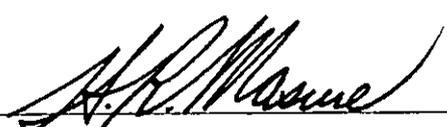
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_



Licensed Embalmer No. 4996

P. O. Address Fulton, Pa.

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.