

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

**5495** **59-040194**  
STATE FILE NUMBER

FILED VS NOV 8 0 1959 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>9 days</u>		c. CITY OR TOWN <u>North Kansas City</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>Trinity Lutheran Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2307 Fayette</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Collin R.</u> Middle <u>Lindberg</u> Last <u>Lindberg</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>12</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>United Wall Paper Co., Mo., M.K.C.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Joliet Ill.</u>	9. AGE (last birthday) <u>61</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
13a. FATHER'S NAME <u>Fred Lindberg</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Josephs</u>	14. NAME OF HUSBAND OR WIFE <u>Laura Lindberg</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW # 1</u>		16. SOCIAL SECURITY NO. <u>327-09-7401</u>	
17. INFORMANT <u>Mrs. Laura Lindberg, No. K.C. Mo</u> Address <u>2307 Fayette</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		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	
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 <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 <u>Nov 1951</u> to <u>Nov 12 1959</u> and last saw him alive on <u>Nov. 12-59</u> Death occurred at <u>6:30/p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Edwin Fischer M.D.</u>		22b. ADDRESS <u>306 E 2, N.K.C. 16 Mo</u>	22c. DATE SIGNED <u>11-13-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-14-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wood Lawn Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Joliet, Ill.</u>
24. FUNERAL DIRECTOR <u>D.W. Newcomer, N.K.C. Mo</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>11-14-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

DOCUMENT

BY AFFIDAVIT OF **H. Fischer** MEDICAL CERTIFICATION

**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

*John V. Henrich*

Licensed Embalmer No. 4848

P. O. Address Sub. 77, m

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.