

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033325

FILED **SEP 7 1960**

Registration District No. **317** Primary Registration District No. **500** Registrar's No. **2541**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy Length of stay in 1b 4 Years c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O'Sullivan Home Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis c. CITY OR TOWN Normandy Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 3715 St. Ann's La. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabel Dora Middle Lindhorst Last Lindhorst			4. DATE OF DEATH Month Aug. Day 26 Year 1960				
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 3/2/1890	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (City and state or country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME John A. James		13b. MOTHER'S MAIDEN NAME Julia Dora Hubert		14. NAME OF HUSBAND OR WIFE William Lindhorst			
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. 500-26-0869		17. INFORMANT Milton Lindhorst Address 6732 Mathew			
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 thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral malaria DUE TO (c) Arteriosclerotic Cardiovascular disease					INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic pyelonephritis, Cholecholecolonic fistula					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 2:00 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 Aug 31, 1957 Aug 26, 1960 and last saw her Aug 22, 1960 alive on Death occurred at 2:00 P m on the date stated above, and to the best of my knowledge from the causes stated.							
22a. SIGNATURE - (Degree or title) Lewis Littmann MD			22b. ADDRESS 8231 Clayton Rd (17)		22c. DATE SIGNED 8/27/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 29, 1960	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.	23e. STATE			
24. FUNERAL DIRECTOR Cullen Kelly ADDRESS 7267 Natural Bridge		25. DATE RECD. BY LOCAL REG. 8-27-60	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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 James G. Lamm

Licensed Embalmer No. 4142

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.