

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048119

FILED VS JAN 5 1961

317

Registration District No. 544

Primary Registration District No. 3805

STATE FILE NUMBER

DEED

|   |  |   |  |   |  |  |   |  |
|---|--|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST LOUIS COUNTY</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>ST LOUIS</b> |  |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KIRKWOOD MO.</b>  |  | Length of stay in 1b<br><b>4 YEARS</b>  |  | c. CITY OR TOWN <b>KIRKWOOD MO.</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>204 THOMAS, KIRKWOOD</b>  |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>204 THOMAS</b>       |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>N</b> Last <b>Lund</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>30</b> Year <b>1960</b>  |  |  |   |  |
| 5. SEX<br><b>M.</b>   | 6. COLOR OR RACE<br><b>W.</b>          | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12-14-1872</b>   | 9. AGE (last birthday)<br><b>88</b>                                      | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HR<br>Hours _____ Min. _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED, ST LOUIS BLDG INS.</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (City and state or country)<br><b>COPENHAGEN, DENMARK</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>UNITED STATES</b>  |   |  |
| 13a. FATHER'S NAME<br><b>NIEL LUND</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>UNKNOWN.</b>   |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>MARIE (DEC)</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>489-20-4757</b>  | 17. INFORMANT Address<br><b>Mrs Jacqueline Schramm, 204 THOMAS KIRKWOOD</b>   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of colon with metastases</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.   |  | Month, Day, Year  |  |   |  |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <b>Nov. 1960</b> to <b>Dec. 30, 1960</b> and last saw him alive on <b>Dec. 30, 1960</b><br>Death occurred at <b>11:00 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |   |  |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Charles E. Henningsen, M.D.</b>  |  |   |  | 22b. ADDRESS<br><b>135 W. Adams, Kirkwood, MO.</b>  |  | 22c. DATE SIGNED<br><b>Dec. 31, 1960</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE<br><b>1-3-1961</b>           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST PETERS CEMETERY</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Kirkwood Missouri</b>   |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Louis H. Bopp Inc.</b>   |  |   | ADDRESS<br><b>131 W. ARGONNE DRIVE</b>   | 25. DATE RECD. BY LOCAL REG.<br><b>1-1-61</b>   | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                          |  |   |  |

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Francis J. Wylona

Licensed Embalmer No. 4517

P. O. Address Kirkwood

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