

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004568

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 99

AMENDED

FILED VS MAR 6 1961

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Pettis</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>3 Days</u>	c. CITY OR TOWN <u>Sedalia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR UNIVERSITY OF MO. <u>Medical Center</u> INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>540 E 4th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>Gilbert</u> Last <u>LINDSTROM II</u>			4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>61</u>		
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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>1-23-61</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u>	IF UNDER 24 HR Hours <u>17</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>Sedalia, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>A/c JAMES G. Lindstrom</u>	13b. MOTHER'S MAIDEN NAME <u>Ruth Umstead</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</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>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>University of Mo. Medical Records</u> Address
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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: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Cong. Heart Disease - Common Truncus Act.</u> <u>17 days</u> DUE TO (c)		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) <u>None</u>		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

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 <u>11:00</u> a.m. <u>P</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Columbia</u>	COUNTY <u>Pettis</u>	STATE <u>Mo.</u>
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21. I attended the deceased from 2/6/61 to 2/9/61 and last saw her/him alive on 2/9/61
Death occurred at 11:00 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Raymond Waterfield MD</u> (Degree or title)	22b. ADDRESS <u>102 Stadium Rd. Columbia</u>	22c. DATE SIGNED <u>2/6/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-13-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>KnobNoster Cemetery</u>	23d. LOCATION (City, town, or county) <u>KnobNoster, Missouri</u>
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24. FUNERAL DIRECTOR <u>The Brauningers, Warrensburg, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 28, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 WPA Banning

Licensed Embalmer No. 3327

P. O. Address Warrensburg

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.