

SSOUR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019236

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4903 STATE FILE NUMBER

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| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>                 |  | Length of stay in 1b   | c. CITY OR TOWN <u>St. Louis</u>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Jewish Hospital</u> |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><u>4011 Blaine Ave.</u>   |
|   |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <u>KNUT</u> Middle <u>D.</u> Last <u>LUNDVALL</u> | 4. DATE OF DEATH<br>Month <u>May</u> Day <u>23</u> Year <u>1961</u> |
|--|---|

|                       |                                  |   |                                      |                                     |                                |                              |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--------------------------------|------------------------------|
| 5. SEX<br><u>Male</u> | 6. COLOR OR RACE<br><u>White</u> | 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><u>6-13-1879</u> | 9. AGE (last birthday)<br><u>81</u> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--------------------------------|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Machinist-W. J. Knight</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Machinery Co.</u> | 11. BIRTHPLACE (City and state or country)<br><u>Sweden</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u> |
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| 13a. FATHER'S NAME<br><u>Unknown Lundvall</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Late Emma K. Lundvall</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> <u>None</u> | 17. INFORMANT<br>Address<br><u>Carl Lundvall 5906 Savio Dr.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DISEASE WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac failure</u> |                             | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <u>Pneumonia</u> |                                  |
|  | DUE TO (c) <u>-</u>         |                                  |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>arteriosclerotic heart disease</u> | 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 |
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| 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.)<br><u>-</u> |
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|   |                  |
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| 20c. TIME OF INJURY<br>Hour <u>-</u> a.m. <u>-</u> 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<br>COUNTY STATE |
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| 21. I attended the deceased from <u>5/9/61</u> to <u>5/22/61</u> and last saw him alive on <u>5/22/61</u><br>Death occurred at <u>2:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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|   |                   |  |                                    |
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| 22a. SIGNATURE<br><u>Hertel A Lund MD</u> | (Degree or title) | 22b. ADDRESS<br><u>16 Hampton Valley</u> | 22c. DATE SIGNED<br><u>5/23/61</u> |
|---|-------------------|--|------------------------------------|

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u> | 23b. DATE<br><u>May 25, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Grove Cemetery</u> | 23d. LOCATION (City, town, or county)<br><u>St. Louis Co. Mo.</u> |
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| 24. FUNERAL DIRECTOR<br><u>Kriegshausler</u> | ADDRESS<br><u>4228 S. Kingshighway Blvd.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>MAY 24 1961</u> | 26. REGISTRAR'S SIGNATURE<br><u>Loan Smith, M.D.</u> |
|--|--|--|--|

DATE AMENDED

INSTEAD OF

SHOULD READ

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

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

Signed William B White

Licensed Embalmer No. 4291

P. O. Address 4328 S. Long St

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.