

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044861

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6444 STATE FILE NUMBER

AMENDED

ISSUED JAN 8 1962

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | c. CITY OR TOWN Kansas City | |
| Length of stay in lb 48 yrs | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Memorial Hosp. | | d. STREET ADDRESS (If outside, give location) 5616 Charlotte | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|----------------------------------|---|--|---|---|
| 3. NAME OF DECEASED (Type or print) SELMA LUNDMARK | | | 4. DATE OF DEATH Month December Day 22 Year 1961 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12-10-1881 | 9. AGE (last birthday) 80 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Sweden | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Carl Anderson | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Martin Lundmark | |
| 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. None | 17. INFORMANT Bert H. Lundmark 5926 Howe Drive | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis | | 49 hrs |
| DUE TO (b) Atherosclerosis, cerebral artery | | 3 yrs |
| DUE TO (c) " " , generalized | | 15 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Ruptured Gastric Ulcer operated | | 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 |

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|---|---|--|--|
| 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 _____ a.m. _____ 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 | COUNTY | STATE |
| 21. I attended the deceased from June 59 to 12-22-61 and last saw her alive on 12-24-61 Death occurred at 7:01 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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|---|------------------------------|--|---|
| 22a. SIGNATURE Charles Lager M.D. | (Degree or title) | 22b. ADDRESS 608 Professional Bldg | 22c. DATE SIGNED 12-24-61 |
| 23a. BURIAL, CREMATION, (EMOWAL) (Specify) Burial | 23b. DATE 12-23-61 | 23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery | 23d. LOCATION (City, town, or county) Kansas City, Missouri |

| | | | |
|---|------------------------------------|---|---|
| 24. FUNERAL DIRECTOR Freeman Mortuary | ADDRESS Kansas City, Mo. | 25. DATE RECD. BY LOCAL REG. 12-24-61 | 26. REGISTRAR'S SIGNATURE Ruth Long |
|---|------------------------------------|---|---|

(Licensed Embalmer's Statement on Reverse Side)

DATE AWARDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF Charles S. Cooper MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

Dr. Ches Cooper
Chas. Bledy

BA 1-2032

11-3

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 *J. R. Green*

Licensed Embalmer No. *2939*

P. O. Address *F. O. 2*

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.