

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019220

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 273

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. FILED JUN 5 1962		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson		a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		c. CITY OR TOWN Kansas City	
Length of stay in 1b 10 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR White Haven Nursing Home INSTITUTION 819 So. Main		d. STREET ADDRESS (If outside, give location) 4523 Park	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First EMIL Middle LINDQUIST Last		Month May Day 26 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1883
9. AGE (last birthday) 78		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile Setter		10b. KIND OF BUSINESS OR INDUSTRY Local # 4	
11. BIRTHPLACE (City and state or country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Nels Lindquist		13b. MOTHER'S MAIDEN NAME Josephina W. Stromberg	
14. NAME OF HUSBAND OR WIFE Florence		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. [REDACTED]		17. INFORMANT Address Mrs. Florence M. Lindquist, 4523 Park	
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral vascular occlusion + anoxia DUE TO (c) Cerebral arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 18 hrs. 18 days
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. <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.)	
20c. TIME OF INJURY Hour 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 May 14, 1962 to May 26, 1962 and last saw <input checked="" type="checkbox"/> live on May 25, 1962 Death occurred at 11 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or Title) Phillip L. Leonard		22b. ADDRESS 1206 W. Huron 24-dulc, Mo	22c. DATE SIGNED 5/26/62
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	May 28, 1962	Calvary Cemetery	Kansas City, Missouri
24. FUNERAL DIRECTOR ADDRESS Melody McGilley-Eylar Funeral Home 1800 E. Linwood		25. DATE RECD. BY LOCAL REG. 5-27-62	26. REGISTRAR'S SIGNATURE Alba L. Craig

Dr. Phillip L. Accardo D. O.
1206 W 24 Highway
Cl. 4-2700

At: ~~Truax & Library
Highway 24 Shop~~

Exchange at Carson FH

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

Gerald A. Burger

Licensed Embalmer No. 4763

P. O. Address K. C. Mo.

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.