

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-045347

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3272

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 16 1962

VS 300  
Rev. 4/59

1 4000

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lemay</b>		Length of stay in lb <b>YRS.</b>	c. CITY OR TOWN <b>Lemay</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>310 Weiss ave.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>310 Weiss</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>A.</b> Last <b>Linder</b>			4. DATE OF DEATH Month <b>November</b> Day <b>8,</b> Year <b>1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-1894</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brewery Worker-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>	9. AGE (last birthday) <b>68</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. FATHER'S NAME <b>Fritz Linder Sr.</b>		11b. MOTHER'S MAIDEN NAME <b>Loretta Rebsamen</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE <b>Sophie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW-1</b>		16. SOCIAL SECURITY NO. <b>WW-1</b>	
17. INFORMANT <b>Sophie Linder 310 Weiss ave.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY INFARCTION</b> DUE TO (b) <b>CORONARY INSUFFICIENCY</b> DUE TO (c) <b>WITH DECOMPENSATION OF HEART</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 MIN.</b> <b>5 years.</b> <b>3 yrs.</b>
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 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.) <b>1953</b>	20f. CITY, TOWN, OR LOCATION <b>death</b> COUNTY _____ STATE _____
21. I attended the deceased from _____ to _____ and last saw her/him alive on <b>Nov 3 1962</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John G. Kellett M.D.</i> John G. Kellett, M. D.		22c. DATE SIGNED <b>11/8/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-10-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>
24. FUNERAL DIRECTOR <b>C. Hoffmeister Mortuaries</b> <b>7814 S. Broadway</b>		23d. LOCATION (City, town, or county) (State) <b>1215 Lemay Ferry Rd. Lemay, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-8-62</b>
26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i>			

USE BLACK INK OR TYPEWRITER RIBBON

SEP 11 1954

*Be Keckitt*

*Delegator - Keck*

**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 *Linus C. Hoffmeister*

Licensed Embalmer No. 3871

P. O. Address 7814 S Broadway

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.