

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039723

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 149

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 22 1963

VS 300
Rev. 4/59

1465

204601

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12 91-0

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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 <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains, Mo.</u> Length of stay in lb <u>15 min.</u>		c. CITY OR TOWN <u>West Plains,</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dr. Rollin Smith's Off.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Sanders Corner Rt.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>C.</u> Last <u>Lindeman</u>			4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/1899</u>
9. AGE (last birthday) <u>64</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Deshler, Nebraska</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>J. D. Lindeman</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine Intleman</u>
14. NAME OF HUSBAND OR WIFE <u>Mathilda Lindeman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>	16. SOCIAL SECURITY NO. <u>[redacted]</u>
17. INFORMANT <u>Mathilda Lindeman, West Plains, Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anaphylactic Reaction to Bee Sting.</u> DUE TO (b) _____ DUE TO (c) _____ 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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>15 Oct 1963</u> to <u>15 Oct 63</u> and last saw him alive on <u>15-10-63</u> Death occurred at <u>10:30 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree Title) <u>[Signature]</u>		22b. ADDRESS <u>West Plains, Mo</u>	
22c. DATE SIGNED <u>17/10/63</u>		23. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/14/63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Howell Memorial Park</u>		23d. LOCATION (City, town, or county) <u>near West Plains, Mo.</u>	
24. FUNERAL DIRECTOR <u>Carter Funeral Home, West Plains, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-18-63</u>	
26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>			

USE BLACK INK OR TYPEWRITER RIBBON

OCT 25 1963

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 *Alfred Carter*

Licensed Embalmer No. 4516

P. O. Address *West Plains, 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.