

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-044627

LED VS DEC 1 1960

Registration District No. 317

Primary Registration District No. 590

Registrar's No. 3388

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Berkley City, Mo.</u>			Length of stay in 1b <u>MONS.</u>		c. CITY OR TOWN <u>St. Louis.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Penn Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3401a No. Florissant</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Emil</u> Middle <u>F.</u> Last <u>Lindo</u>				4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10/8/1886</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationery Engr.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Master Built Refrig.</u>		11. BIRTHPLACE (City and state or country) <u>Iron Mt., Missouri.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Charles Lindo</u>			13b. MOTHER'S MAIDEN NAME <u>Bertha Manning</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret (Thomsen) Lindo.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>Nil.</u>		17. INFORMANT <u>Mr. Carl Lindo, 8895 Berkey, Jennings, Mo.</u> 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) <u>Arteriosclerotic Heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <u>Senile dementia (mania)</u>					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 _____ Month, Day, Year _____ a.m. _____ p.m. _____							
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>Jan 17, 1959</u> to <u>Nov 21, 1960</u> and last saw him alive on <u>11/20/60</u>			Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>Loves Kuttmann MD</u> (Degree or title)				22b. ADDRESS <u>8231 Clayton Rd (17)</u>		22c. DATE SIGNED <u>11/21/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11-21-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) <u>Mount Olive, Illinois.</u>		
24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>11-21-60</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 1 1898

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eaton R. Reme

Licensed Embalmer No. 428

P. O. Address St. Louis

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.