. No. 2
-4-13-40
5-17-39
I X23159

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29641

Registration District No. 784 Primary Registration District No. 509 Registrar's No. 1584

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town ~~St. Louis County~~ Maplewood
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 7415 Flora 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days) 535

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Maplewood
(If outside city or town limits, write "RURAL")

(d) Street No. 7415 Flora
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Albert Monroe Lindenman

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased June (Month) 9 (Day) 1870 (Year)

8. AGE: Years 70 Months 2 Days 9 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Illinois (State or foreign country) 1

10. Usual occupation Blacksmith

11. Industry or business WPA

FATHER
12. Name John Lindenman 9
13. Birthplace Unknwon (City, town, or county) ..... (State or foreign country) 1

MOTHER
14. Maiden name Unknown 9
15. Birthplace Unknown (City, town, or county) ..... (State or foreign country) 9

16. (a) Informant W. S. Yoder
(b) Address 7415 Flora

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-19-40 (Month) (Day) (Year)
(c) Place: burial or cremation Carthage, Mo.

18. (a) Signature of funeral director Albert H. Hoppe Inc.
(b) Address 4700 Washington Blvd.

19. (a) AUG 20 1940 (Date received local registrar) (b) R. R. Meyer M.D. D.P.H. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 18 year 1940 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from Aug. 13, 1940, to Aug. 18, 1940, that I last saw him alive on Aug. 17, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of intestine	
Due to	
Due to 46	
Other conditions acute retention (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature [signature] (M. D. ~~[illegible]~~)
Address 7266 Manchester Date signed 8/19/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2971

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.