MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

32476

1. PLACE OF DEATH
County Stoddard — Registration District No. 837 — File No.
Township Castor — Primary Registration District No. 6099 — Registered No.
City — (No. ..... St. ..... Ward)

2. FULL NAME Ivern Linsey
(a) Residence. No. Flat River St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 25 - 1925
7. AGE: Years 1 — Months 21 — Days — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) Linett Mo
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Arthur Linsey
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Kansas
12. MAIDEN NAME OF MOTHER Pansey Blakely
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind
(STATE OR COUNTRY)

14. INFORMANT C. L. Blakely
(Address)
15. FILED 10/18, 1927 S. S. Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-14 1927
17. I HEREBY CERTIFY, That I attended deceased from 10-14 2 P m, 1927, to 4 P 10-14, 1927, that I last saw him alive on 10-14 2 P m, 1927, and that death occurred, on the date stated above, at 4 P m m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tyfthrea
10
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) dont know
(duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH? —
9 DID AN OPERATION PRECEDE DEATH? — DATE OF —
WAS THERE AN AUTOPSY? —
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) O R Reynolds, M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Hillside Cemetery — DATE OF BURIAL: 10-15 1927
20. UNDERTAKER: J. A. Chiles — ADDRESS: Bloomfield

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Stoddard Registration District No. 837 File No.

Township Castor Primary Registration District No. 6099 Registered No.

City (No. St. Ward)

2. FULL NAME Ivern Linsy

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
m	w	S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 15 1925

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
X	1	9	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. X FILED 10-18, 1927 S. S. Davis X
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14 1927

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

X as we understand, the cause of death was Diptheria yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) O. R. Reynolds, M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

10

5-32476