WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Do not use this space.

34213

1. PLACE OF DEATH
County Johnson — Registration District No. 479 — File No. 117
Township Washington — Primary Registration District No. 4755 — Registered No.
City Knob Noster (No. ..... St. ..... Ward)

2. FULL NAME Jno. Linhardt
(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 3 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): Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar-13-1844

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
85	7	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(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) Cole Co. Mo.

PARENTS

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

14. INFORMANT Mrs Caroline Wulfrum
(Address) Knob Noster Mo

15. FILED 9/25 1929 J. A. Koch
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 22 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929 to Oct 22, 1929, that I last saw him alive on Oct 22, 1929 and that death occurred, on the date stated above, at 12 30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
(1) Chr Valvular Disease
131
92 A
97 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) (1) Chr interstitial nephritis
(2) arterio Sclerosis
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J. W. Grove, M. D
, 19 (Address) Knob Noster Mo

*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: Lohman Mo
DATE OF BURIAL: 10/24 1929

20. UNDERTAKER: C. L. Sault
ADDRESS: K. N. Mo