

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City, Mo.

Registration District No. 399
Primary Registration District No. 1002
Genl Hospital

File No. 14343
Registered No. 1860
St. _____ Ward _____

2. FULL NAME

Oscar Linton
(a) Residence. No. 1717 Holmes 3 Ward.

(Usual place of abode) Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 15 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
58 3 17

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 237
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N.C. 3

PARENTS
10. NAME OF FATHER Pleasure Linton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) N.C.
12. MAIDEN NAME OF MOTHER Dont know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Dont know

14. INFORMANT Record Clerk
(Address) General Hoo. No. 2

15. FILED 4/21 31 M. M. Crowe REGISTRAR
Wor

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-18 1931

17. I HEREBY CERTIFY, That I attended deceased from 4-11 1931, to 4-18, 1931 that I last saw h. live alive on 4-18, 1931, and that death occurred, on the date stated above, at 2:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108/108 (duration) _____ yrs. _____ mos. 8 ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 1717 Holmes
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) S. M. Miller M. D.
4/19 1931 (Address) Genl Hopt #2

*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 Blue Ridge Lawn Cem DATE OF BURIAL 4-22-31
19

20. UNDERTAKER Flynn + Greenstreet ADDRESS K.C., Mo.

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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

