

Registration District No. 397

Primary Registration District No. 1002

Registrar's No. **3974**

1. PLACE OF DEATH:
(a) County Jackson **NOV 14 1939**
(b) City or town Kansas City
(c) Name of hospital or institution: 3241 Wabash **3**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 60 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles Linn **5**
8. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mrs. Theresa Linn 6. (c) Age of husband or wife if alive No years
7. Birth date of deceased August 31 1854
(Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 14 If less than one day hr. min.

9. Birthplace Ripley Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Shoemaker

11. Industry or business

MOTHER FATHER { 12. Name Christian Linn
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Elegar
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Henry Heuss
(b) Address 124 W 61st St Kansas

17. (a) Burial (b) Date thereof Oct. 17, 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director John W. Wagner
(b) Address Kansas City, Missouri

19. (a) 10/16/39 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 10409 East 15th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 14th
year 1939 hour 3:00 minute _____ P. M.
21. I hereby certify that I attended the deceased from Oct 13
1939, 19to Oct 17, 1939
that I last saw him alive on Oct 14, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arteriosclerosis - 1
Intestinal - 1/2 ?

Due to Primary seat unknown
Due to _____

Other conditions Emphysema
(Include pregnancy within 3 months of death)

Major findings: seen
Of operations _____
Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Paul H. Hildy, M.D. (M. D. or other) _____
Address 1232 Prof. Hildy Date signed 10-16-39

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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

FORM 347-39
Rev. 6-17-39
U.S. GPO: 1939 O-19151

Dr. Glen Broyles,

Prof. Rg

VI 4222

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 A. R. Haunschild

Licensed Embalmer No. 4062

P. O. Address K. C. Mo.

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 this body is not embalmed, above space should be left blank.