DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38628

Registration District No. 399 — DEC 11 1939

Primary Registration District No. 1002

Registrar's No. 4392

1. PLACE OF DEATH: 2

(a) County Jackson

(b) City or town Kansas City Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1017 Harrison (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) Lifetime

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Mo (b) County Jackson

(c) City or town Kansas City Mo. (If outside city or town limits, write "RURAL")

(d) Street No. 1017 Harrison (Rear) K C Mo. (If rural, give location)

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

3. (a) PRINT FULL NAME ERNEST LINWOOD 530

3. (b) If veteran, name war Don't Know

3. (c) Social Security No. Don't Know

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife No

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

7. Birth date of deceased Nov (Month) 9 (Day) 1869 (Year)

8. AGE: Years about 78 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Kansas City, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Cotton Sampler

11. Industry or business 0

FATHER
12. Name Don't Know
13. Birthplace Don't Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Don't Know
15. Birthplace Don't Know (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Coroner's Record

(b) Address Jackson Co Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-17-39 (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Western Dental Col

18. (a) Signature of funeral director Flynn + Greenstreet

(b) Address KC Mo

19. (a) Nov 17 1939 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 2-39 year hour 5 minute M.

21. I hereby certify that I attended the deceased from [signature] 19__, to 19__; that I last saw alive on 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Anasarca

Due to Myocardial Failure

Due to 93 B

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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. or other)

Address [signature] Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.

NOV. 5-17-39 I X19511

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 Edw G Evans

Licensed Embalmer No. 3836

P. O. Address 1819 E 15th ST 15 CMCO

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.