

NOV 12 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34697

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4123

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 days  
(Specify whether  
In this community 50 years  
years, months or days)

3. (a) PRINT FULL NAME GUS LINDERT  
(b) If veteran, name war no  
3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years 69 Months -- Days -- If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired R.R. Fireman

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name unknown  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant General Hospital Records  
(b) Address Kansas City, Mo.

17. (a) Removal (b) Date thereof 10-28-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill, I.C. Kans

18. (a) Signature of funeral director Edw. Bros Funeral Hse  
(b) Address 1416 Main Ave

19. (a) 10-28-40 (b) M. M. Brown  
(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. 3616 East 10th St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27th  
year 1940 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from Oct. 15th 1940 to Oct. 27th 1940;  
that I last saw him alive on Oct. 27th, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death PRIMARY CAECINOMA OF RECTUM

Due to \_\_\_\_\_

Due to 46

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy See above

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)  
(a) Means of injury !

23. Signature Wm R. Thorne (M. D. or other) \_\_\_\_\_  
Address Med. Dir. K.C. Gen. Hospital, K. Mo.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 Arnold H. Beckwith

Licensed Embalmer No. 3937

P. O. Address Kansas City, Kansas

**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.**