No. 2
13-40
7-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Dr. Todd
Williamstown

State File No. 42159

JAN 25 1941

Registration District No. 190

Primary Registration District No. 5274

Registrar's No. 41

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

1. PLACE OF DEATH:
(a) County Clark Co
(b) City or town Canton Mo R R
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Jackson Tp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 2 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Clark
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Susie Catherine Linnen
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife James Linnen
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct 1 (Month) 1863 (Day) (Year)

8. AGE: Years 77 Months 2 Days 21 If less than one day hr. min.

9. Birthplace Clark Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation Farming
11. Industry or business
FATHER
12. Name Alois Renner
13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Isabelle V. Simpson
15. Birthplace Ohio (City, town, or county) (State or foreign country)
16. (a) Informant Evelyn Ford
(b) Address Canton Mo R R
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24-40 (Month) (Day) (Year)
(c) Place: burial or cremation St Patrick
18. (a) Signature of funeral director A. C. Terth
(b) Address Memphis Mo
19. (a) 12-4-40 (Date received local registrar) (b) J R Briggs (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22 year 1940 hour 12 minute 30 P M.

21. I hereby certify that I attended the deceased from Dec 2, 1940, to Dec 22, 1940 that I last saw her alive on Dec 22, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of mesentary	3 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? 1 7 4 (Specify type of place)
While at work? (e) Means of injury 3

23. Signature Dr. C. E. Todd (~~M. D. or~~ other) DO
Address Williamstown Mo Date signed 12/28/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 1-41-80
Date Filed JAN 13 1941

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. C. Gerth

Licensed Embalmer No. 3689

P. O. Address Memphis T

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-4-25-41
I X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42159

Registration District No. 190 Primary Registration District No. 5274 Registrar's No.

1. PLACE OF DEATH:
(a) County Clark
(b) ~~City or town~~ Jackson Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community n

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Susie Catherine LENNIN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

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

8. AGE: Years 77 Months 2 Days 21 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 4-25-41 (Date received local registrar) (b) J. R. Bridges (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22 year 1940 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 C. E. Todd (M. D. or other)
Address Williamstown Mo Date signed

SUPPLEMENTARY

1940
S-42159