

JAN 13 1942

Registration District No. 849

Primary Registration District No. 6120

Registrar's No. 16

1. PLACE OF DEATH:  
(a) County Sullivan Madison Mo.  
(b) City or town Corning, Mo.  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Sull. 105  
(c) City or town Rural 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. address Corning Mo. 0  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sheila Kay LINHART  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month DEC day 6  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from DEC-4  
1941 to DEC 6 1941  
that I last saw HER alive on DEC-5 1941  
and that death occurred on the date and hour stated above.

4. Sex F 1. Color or race W  
6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Nov 14 1941  
(Month) (Day) (Year)  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: BRONCHIAL PNEUMONIA ✓ 2 days  
Duration  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace SULLIVAN Mo. 0  
(City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name Dewey LINHART  
13. Birthplace Sullivan Mo. 0  
(City, town, or county) (State or foreign country)  
14. Maiden name Lystell MORRIS  
15. Birthplace Sullivan Mo. 0  
(City, town, or county) (State or foreign country)  
16. (a) Informant Dewey Linhart  
(b) Address Corning, Mo.  
17. (a) Burial (b) Date thereof Dec 6 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Baker Cem.  
18. (a) Signature of funeral director Neighbors, Corning, Mo.  
(b) Address \_\_\_\_\_  
19. (a) Dec 31-1941 (b) Virginia Gibson  
(Date received local registrar) (Registrar's signature)

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 0  
23. Signature V. Gibson (M-D or other) \_\_\_\_\_  
Address Corning, Mo. Date signed 12-9-41

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

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

RECEIVED

District Health Officer No. 10

District File Number 1-42-20

Date Filed JAN 9 1942

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 43186

Registration District No. 849

Primary Registration District No. 6125

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Rural  
(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  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Shelia R. Linhart

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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 14 1941  
(Month) (Day) (Year)

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

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day \_\_\_\_\_  
Year 1941 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Pneumonia  
Due to whooping cough

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

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

Major findings: \_\_\_\_\_  
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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (b) Means of injury \_\_\_\_\_

23. Signature J. E. Schur (M. D. or other) \_\_\_\_\_

Address Spain City Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

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

S-4318b