

MAY 11 1943

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Community Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby
(c) City or town CLARENCE
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Daisy Constant Maude Linson

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 Widowed
6. (b) Name of husband or wife John William Linson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Apr 29 1873
(Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name John Herriott
13. Birthplace W. Va. (City, town, or county) (State or foreign country)
14. Maiden name Tebara Ellen Parke
15. Birthplace W. Va. (City, town, or county) (State or foreign country)

16. (a) Informant Wibbey C. Linson

(b) Address Shelburne MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Cherry Box

18. (a) Signature of funeral director C. E. Kopper

(b) Address Clarence, Mo

19. (a) 4/8/43 (Date received local registrar) (b) Mrs. J. Wagoner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29 year 1943 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from March 19 1943 to March 29 1943; that I last saw her alive on March 28 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocardial Failure
Due to Chronic Myocarditis

Due to _____
Other conditions None (Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy No 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 2

23. Signature A. P. Schultz (M.D. number) DD
Address Community Nursing Home Date signed 3/30/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

43-3-29
73-4-29

RECEIVED

District Health Officer No. 10

District File Number ~~MAY 10 1943~~ 833

Date Filed

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 *Louis E. Kopper*

Licensed Embalmer No. *4261*

P. O. Address *Clawson, 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, fact should be so stated above.