

S. No. 2
M-8-13
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30200

State File No.

FILED OCT 9 1944
Registration District No. 197

Primary Registration District No. 1002

Registrar's No. 3892

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

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 7 1/2 hrs.
(Specify whether
 In this community Callan
years, months or days)

3. (a) PRINT FULL NAME Linderman Infant A
 3. (b) If veteran, name war no
 3. (c) Social Security No. none.
 4. Sex Female
 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 August 24 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 1/2 hr. min.

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

10. Usual occupation infant

11. Industry or business X

MOTHER FATHER {
 12. Name
 13. Birthplace 9
(City, town, or county) (State or foreign country)
 14. Maiden name Lorain Linderman
 15. Birthplace Michigan
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
 (b) Address General Hospital No. 1

17. (a) Burial
(burial, cremation, or removal)
 (b) Date thereof 9-19-44
(Month) (Day) (Year)
 (c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director Wm. B. Schumpe

(b) Address City, Mo.
 19. (a) 9-27-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
 (d) Street No. 3004 E. 23 St. 9
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August 24
 year 1944 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from August 24 1944 to August 24 1944
 that I last saw her alive on August 24 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Premature
 Due to
 Due to
 Other conditions 159
(include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy See above

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

Where did injury occur?
 (c) (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

23. Signature W. E. Usher (M.D.) MD
 Address Med. Dir. Gen'l Hosp. Date signed 8-25-44

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.