

FILED SEP 20 1945

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1801

Registrar's No. 3673

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
K. C. General Hospital # 1, 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day
(Specify whether)

In this community 54 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48

(c) City or town K. C. 3
(If outside city or town limits, write "RURAL")

(d) Street No. 7613 Pennsylvania Ave. 8
(If rural, give location)

(e) Citizen of foreign country? No 0
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Fredrick C. Linthicum

3. (b) If veteran, name war No

3. (c) Social Security No. 500-14-0159

4. Sex Male 0 5. Color or race W

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

6. (b) Name of husband or wife Josephine B. 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Feb. 12, 1891
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>54</u>	<u>6</u>	<u>22</u>	<u>0</u> hr. <u>0</u> min.

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

10. Usual occupation Dispatcher

11. Industry or business Plaza Cab Co.

MOTHER FATHER { 12. Name Jess E. Linthicum

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

{ 14. Maiden name Daisy Paulk

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

16. (a) Informant Josephine B. Linthicum

(b) Address 7613 Pennsylvania Ave.

17. (a) Burial (b) Date thereof Sept. 6, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quindaro Cem., K. C. Ks.

18. (a) Signature of funeral director C. H. Blackman & Son

(b) Address 2825 Independence Blvd., K.C. Mo.

19. (a) 9-4-45 (b) M. Geraldine Holmes
(Data received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2
year 1945 hour 1 minute 04 A. M.

21. I hereby certify that I attended the deceased from 9-
1, 1945, to 9-2, 1945
that I last saw him alive on 9-2, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Heart failure
Due to Hemorrhage into peri-
cardium (coronary thrombosis)
Due to Syphilitic atherosclerosis
of ascending aorta.

Other conditions
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations 30 d

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)

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

While at work? (Specify type of place)
(Specify type of place) (c) Means of injury _____

23. Signature M. Geraldine Holmes (M.D. or other) _____
Address General Ave. Date signed 9-2-45

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

18
3
8

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. 3639

P. O. Address K. C. 1, 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.