

Registration District No. **172** Primary Registration District No. **8084** Registrar's No. **34**

**1. PLACE OF DEATH:**  
 (a) County **Rafayette**  
 (b) City or town **Higginsville**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution **1**  
(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 **Rafayette**  
 (c) City or town **Higginsville**  
(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** **Herman Lindhorst**  
**3. (b) If veteran,** \_\_\_\_\_ **3. (c) Social Security No.** **495-01-4895**

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **August** day \_\_\_\_\_ year **1946** hour **5** minute \_\_\_\_\_ AM/PM  
**21. I hereby certify that I attended the deceased from** **July 31**, 1946, to **August 1**, 1946, and that death occurred on the date and hour stated above.  
 Immediate cause of death **Myocarditis**  
 that I last saw him alive on **August 1**, 1946.

**4. Sex** **male** **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** **Dec - 8 - 1872**  
(Month) (Day) (Year)

Due to **asthma**  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

| 8. AGE: | Years     | Months   | Days      | If less than one day |
|---------|-----------|----------|-----------|----------------------|
|         | <b>73</b> | <b>7</b> | <b>23</b> | hr. _____ min. _____ |

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

**10. Usual occupation** \_\_\_\_\_  
**11. Industry or business** **Retired**  
**MOTHER FATHER**  
**12. Name** **John A Lindhorst**  
**13. Birthplace** **Germany**  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **Anna Kappel**  
**15. Birthplace** **Germany**  
(City, town, or county) (State or foreign country)  
**16. (a) Informant** **Ralph Lindhorst**  
**(b) Address** **Higginsville Mo**  
**17. (a) (Burial, cremation, or removal)** **Buried** **(b) Date thereof** **8-3-46**  
(Month) (Day) (Year)  
**(c) Place: burial or cremation** **Higginsville**  
**18. (a) Signature of funeral director** **W. Meinershagen**  
**(b) Address** **Higginsville Mo**  
**19. (a) 8-3-1946** **(b) Clayton T. Landrum**  
(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? \_\_\_\_\_  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury **2**  
**23. Signature** **Leon L. Greener** (M. D. or other) **MD**  
**Address** **Higginsville Mo** **Date signed** **8-1-46**

**Duration** \_\_\_\_\_  
**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

District File Number

Date Filed 8-17-42

7800

271

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 Roy F. Wieggers  
Licensed Embalmer No. 2883  
P. O. Address Higginsville, 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.

*Clarence A. [unclear]*

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