

FILED APR 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 130591  
Registrar's No. 8

Registration District No. 114

Primary Registration District No. 5432

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Rural Sullivan R # 2  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Melrose TWP 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 34 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Franklin  
(c) City or town Sullivan mo. Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Melrose TWP  
(If rural, give location)  
(e) Citizen of foreign country? yes mo (Yes or No)  
If yes, name country Germany

3. (a) PRINT FULL NAME CARL LINEBERGER

3. (b) If veteran, \_\_\_\_\_ name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex mo 5. Color or race w  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Roxie Lindenger  
6. (c) Age of husband or wife if alive 55 years  
7. Birth date of deceased March 12 1874  
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 2 If less than one day hr. 11 min.

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

10. Usual occupation Farmer

11. Industry or business own farm

12. Name wife

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

14. Maiden name wife  
15. Birthplace wife  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Carl Lineberger

(b) Address Sullivan R # 2, mo

17. (a) burial (b) Date thereof 4/16/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rock Hill Cemetery

18. (a) Signature of funeral director Casey + Senox

(b) Address H. Clark

19. (a) 4-14-47 (b) Ch. Prater  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14  
year 1947 hour 10 minute 15 a.m.

21. I hereby certify that I attended the deceased from 1946, 1946 to 4-24-1947, 1947  
that I last saw him alive on 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 20 days  
Due to Chronic Rheumatic Heart years  
Due to Congestive heart failure months

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy none  
PHYSICIAN Ch. Prater  
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 \_\_\_\_\_  
(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 Ch. Prater (M. D. or other) 0  
Address Sullivan mo Date signed 4/17/47

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

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed

4-23-47

JUL 3 1947

MAY 6 1947

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 J. M. Ferret

Licensed Embalmer No. 3601

P. O. Address St. Clair, 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.