

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15350**
Registrar's No. **3819**

FILED APR 21 1947
318

1003

Registration District No. _____
Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: PARKLANE Memorial Hospital
(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 _____
(c) City or town Pacific
(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 "Baby" LINNENBRINK
FULL NAME
(b) If veteran, name war NO (c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 8th
year 1947 hour 2 minute 15 A.M.

4. Sex male 5. Color or race wh.
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 6 years (Day) (Year)

21. I hereby certify that I attended the deceased from April 7, 1947 to Apr 8, 1947
that I last saw her alive on Apr 7, 1947
and that death occurred on the date and hour stated above.

7. Birth date of deceased: APRIL (Month) 7 (Day) 1947 (Year)
8. AGE: Years _____ Months _____ Days _____ If less than one day 7 hr. 15 min.

Immediate cause of death: Intercranial Hemorrhage
Tentorial tear on left side
Due to _____
Duration 7 hours

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy Same as above

11. Industry or business _____
12. Name ARTHUR LINNENBRINK
13. Birthplace Loose Creek (City, town, or county) Mo. (State or foreign country)
14. Maiden name ROSELA MANETE
15. Birthplace _____ (City, town, or county) Mo. (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Arthur Linnenbrink
(b) Address Pacific Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (Month) (Day) (Year)
(c) Place: burial or cremation Pacific Mo.

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? _____

18. (a) Signature of funeral director J. F. Brecken
(b) Address _____
19. (a) APR 11 1947 (Date received local registrar) (b) J. F. Brecken (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature E. O. Brecken (M. D. or other) _____
Address Maplewood Mo Date signed 4/8/47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER, FATHER

6188

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.

This body was not embalmed.

Signed *Geo. T. Hughes*.....

Licensed Embalmer No. *3008*.....

P. O. Address *Pacific 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.