S. No. 2
OM—5-43
v. 5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38282

Registration District No. 749 Primary Registration District No. 1002 Registrar's No. 4674

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: Devine Brothers Clinic 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Weeks (Specify whether
In this community 3 Weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Nebraska (b) County Scottsbluff 999 25 0

(c) City or town Morrill
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

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

If yes, name country 2

3. (a) PRINT FULL NAME SCOTT D. LINGLE

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Della Lingle

6. (c) Age of husband or wife if alive years

7. Birth date of deceased December (Month) 14th. (Day) 1872 (Year)

8. AGE: Years 74 Months ~~11~~ 10 Days ~~2~~ 24 If less than one day hr. min.

9. Birthplace Irving (City, town, or county) Illinois (State or foreign country) 1

10. Usual occupation Retired

11. Industry or business Farming

FATHER
12. Name John J. Lingle 1
13. Birthplace (City, town, or county) Pennsylvania (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Jacob J. Lingle

(b) Address Ashland, Oregon

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11 - 8 - 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Irving, Illinois

18. (a) Signature of funeral director Freeman Mortuary & Chapel

(b) Address 104 West 42nd. St. Kansas City, Mo.

19. (a) 11-8-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 8th year 1947 hour 9 minute 40 A.M.

21. I hereby certify that I attended the deceased from Oct 18, 1947, to Nov 8th, 1947, that I last saw him alive on Nov 18th, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Circulatory failure	2 weeks
Due to: Decompensated hypertensive heart disease	4 weeks
Due to: Chronic glomerulonephritis of unknown cause	4 weeks
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 131 b

Of autopsy

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

(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 V J Devine (M. D. or other) DO

Address 914 Oak Date signed 11-8-47

(Licensed Embalmer's Statement on Reverse Side)

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. 2939

P. O. Address K. C. 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.