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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED APR 12 1948

Registration District No. 149

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 8800

Registrar's No. 1355

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:
815 WEST 58TH STREET TERRACE 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 28 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL")

(d) Street No. 815 WEST 58TH STREET TERRACE 8
(If rural, give location) 0

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

If yes, name country - - - - - -

3. (a) PRINT FULL NAME MRS. MARY LINNETT LINVILLE

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE 1

5. Color or race WHITE

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ WIDOWED

6. (b) Name of husband or ~~wife~~ MR. JOHN LINVILLE

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

7. Birth date of deceased OCTOBER (Month) 17 (Day) 1870 (Year)

8. AGE: Years 77 Months 5 Days 6 If less than one day ___ hr. ___ min.

9. Birthplace HENRY COUNTY (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation NONE

11. Industry or business AT HOME

FATHER
12. Name JACOB HOBBS 1
13. Birthplace (City, town, or county) ILLINOIS (State or foreign country)

MOTHER
14. Maiden name MATILDA SACHRIDER 1
15. Birthplace (City, town, or county) ILLINOIS (State or foreign country)

16. (a) Informant DR. A. E. LINVILLE
(b) Address 815 W. 58th ST., K.C., MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR 27 1948 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ MT. WASHINGTON CEM.

18. (a) Signature of funeral director D. W. Newcomer's Sons
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 3-27-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 23RD
year 1948 hour 10 minute 05 P.M.

21. I hereby certify that I attended the deceased from July, 1945, to March 23, 1948
that I last saw her alive on March 19, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Myocardial Failure	Immediate
Due to Chronic Myocardial Decompensation	Nov, 1947
Due to Arteriosclerosis et Chronic Interstitial Nephritis	Several yrs. Nov-1947
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None 131a
Of autopsy None

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 Nelson Myers D.O. (M. D. or other)
Address 612 Twelfth & Walnut Bldg. Date signed 3-24-48

(Licensed Embalmer's Statement on Reverse Side)

Chambers Funeral

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 Jos T. Rees

Licensed Embalmer No. 445-3

P. O. Address Kansas City

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.