

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 23 1949

BIRTH NO. _____ REG. DIST. NO. 183 PRIMARY REG. DIST. NO. 4296 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>SULLIVAN</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BROWNING</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural MORRIS TWP</u>	
c. LENGTH OF STAY (in this place) <u>1 mo.</u>		d. STREET ADDRESS (If rural, give location) <u>R.R. Browning</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BROWNING</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Reuben</u> b. (Middle) _____ c. (Last) <u>LINHART</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 4 - 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>FEBRUARY 24 - 1872</u>		9. AGE (In years last birthday) <u>77</u>		10. MONTHS <u>0</u> DAYS <u>8</u> HOURS <u>0</u> MIN. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ON FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>William Linhart</u>		13b. MOTHER'S MAIDEN NAME <u>Aranda Robinson</u>		14. NAME OF HUSBAND OR WIFE <u>Rushie Linhart</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Rushie Linhart</u> ADDRESS <u>Browning</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u>
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive head disease</u>				
		DUE TO (c) <u>331X</u>				
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis</u>				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from Aug 1875 to March 3, 1949, that I last saw the deceased alive on March 3, 1949, and that death occurred at 12:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. P. McArthur M.D.</u>		23b. ADDRESS <u>Browning</u>		23c. DATE SIGNED <u>March 7 49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>March 6 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Baker Cemetery Sullivan Co. Mo.</u>		24d. LOCATION (City, town, or county) (State)	
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DATE REC'D BY LOCAL REG. <u>Mar. 8, 49</u>		REGISTRAR'S SIGNATURE <u>Elva Crookshank</u>		1646		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Glenice E. West, Son Green City</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Karl R. Kent

Student Embalmer No. *242*

working under my personal supervision.

Signed.....

Karl R. Kent
Student Embalmer

Signed.....

Archie W. Wade

Licensed Embalmer No. *3037*

P. O. Address.....

Greenville S.C.

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.