

FILED APR 12 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 11298

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6228 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Stotesbury</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Stotesbury</u>	
c. LENGTH OF STAY (In this place) <u>74 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>No Street Address</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>No street Address</u>		e. STREET ADDRESS (If rural, give location) <u>No Street Address</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>Linn</u> c. (Last) <u>Linn</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 30, 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wht. Am.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 6, 1874</u>
9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Small Grain</u>	11. BIRTHPLACE (State or foreign country) <u>Stotesbury, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Jim Linn</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Allen</u>	
14. NAME OF HUSBAND OR WIFE <u>Minnie Minor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>don't know</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Samuel Bullard</u>		ADDRESS <u>3288 Douglas St. Okla. City, Okla.</u>	
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>Coronary Insufficiency</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>Apr 5 1949</u>		19b. MAJOR FINDINGS OF OPERATION <u>No operation</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Jan 1946</u> to <u>Mar 1949</u> that I last saw the deceased alive on <u>Mar. 30, 1949</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>William H. Allen, M.D.</u>		23b. ADDRESS <u>Home No</u>	
23c. DATE SIGNED <u>4/2/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>4/1/1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Bourbon Co., Kansas</u>	
DATE REC'D BY LOCAL REG. <u>Apr. 5 - 1949</u>		REGISTRAR'S SIGNATURE <u>Kathryn H. Young</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>O.A. Cheney</u>		ADDRESS <u>Ft. Scott, Mo.</u>	

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

RECEIVED

District Health Officer No. 7,

District File Number 3-49-262

Date Filed 4-11-49

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 _____

Albert N. Cheney

Student Embalmer No. _____

working under my personal supervision.

Signed Albert N. Cheney
Student Embalmer

Signed Albert N. Cheney

Licensed Embalmer No. 2612

P. O. Address Fort Scott, Kansas.

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.