No. 300
10-48

FILED DEC 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41189

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5144

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

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): 34 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 721 Cambridge Tr

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Indiana
b. COUNTY: LA PORTE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): La Porte
d. STREET ADDRESS (If rural, give location): 412 E. Maple

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): C.
c. (Last): Linnell

4. DATE OF DEATH (Month) 12 (Day) 4 (Year) 49

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 10/28/1882
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months 1 Days 7 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Jasper Linnell
13b. MOTHER'S MAIDEN NAME: Unk
14. NAME OF HUSBAND OR WIFE: Ethel Linnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 315-18-0063
17. INFORMANT'S SIGNATURE OR NAME: Ethel Linnell, LA PORTE, IND — ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: Undet 4-6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Metastasis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Generalized Metastasis 3-4

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 162X
20. AUTOPSY? YES ☐ NO ☒

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):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-2, 1949, *to* 12-4, 1949, *that I last saw the deceased alive on* 12-1, 1949, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Leo M. Mullen — Leo M. Mullen MD
23b. ADDRESS: 3548 Indiana
23c. DATE SIGNED: 12-5-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 12/6/49
24c. NAME OF CEMETERY OR CREMATORY: —
24d. LOCATION (City, town, or county) (State): La Porte Indiana

DATE REC'D BY LOCAL REG.: 12-5-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: John P. Sheil — ADDRESS: K.C. Mo.

(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 _____

_____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed John P. Shiel

Licensed Embalmer No. 3625

P. O. Address K.C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.