

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43698

State File No.

FILED DEC 26 1951
BIRTH NO. 19861-51 REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 226

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall	
d. FULL NAME OF HOSPITAL OR INSTITUTION 760 South Salt Pond		d. STREET ADDRESS (If rural, give location) 760 South Salt Pond	

3. NAME OF DECEASED (Type or Print) Linda Kay French			4. DATE OF DEATH (Month) (Day) (Year) Dec. 18 1951		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH March 20-1951		9. AGE (In years last birthday) 8		10. IF UNDER 1 YEAR Days 18 Hours Min. 	
11. BIRTHPLACE (State or foreign country) Marshall, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Thomas E. French		13b. MOTHER'S MAIDEN NAME Fay Robbins		14. NAME OF HUSBAND OR WIFE 	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Thomas E. French ADDRESS Marshall, Missouri	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Bronchitis INTERVAL BETWEEN ONSET AND DEATH 5-6 days ANTECEDENT CAUSES DUE TO (b) None. DUE TO (c) None. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) Marshall Saline Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 **12-27-1957**, to **18-12-57**, 1927, that I last saw the deceased alive on **16-27-1957**, and that death occurred at **12-27-1957** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L. C. Commissioner Tr. 10.		23b. ADDRESS Marshall Mo.		23c. DATE SIGNED 12-18-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/18/51		24c. NAME OF CEMETERY OR CREMATORY Arrow Rock Cemetery	
24d. LOCATION (City, town, or county) (State) Arrow Rock, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. Leslie Sweeney - Marshall, Mo.			

DATE REC'D BY LOCAL REG. Dec 18-1951		REGISTRAR'S SIGNATURE Lidney T. Gray		385	
---	--	---	--	-----	--

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 12-24-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 12-26-51 _____

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 _____

Licensed Embalmer No. 32350

P. O. Address Marshall, 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.