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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26637

State File No.

FILED JUL 31 1953

318

1003

Registrar's No. 6692

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE _____ b. COUNTY _____
Mo.

b. CITY (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (in this place)
OR TOWN St. Louis, Missouri
c. CITY (If outside corporate limits, write RURAL and give township)
OR TOWN St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital
d. STREET ADDRESS (If rural, give location)
16 3400 S. Grand Blvd.

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) J. c. (Last) LINNE Sr.
4. DATE OF DEATH (Month) (Day) (Year) JULY 5, 1953

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH April 9, 1880
9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman-Boyd Richardson Co. 10b. KIND OF BUSINESS OR INDUSTRY Richardson Co. 11. BIRTHPLACE (City and State or Foreign Country) Waterloo, Ill. 12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME Fred Linne 13b. MOTHER'S MAIDEN NAME Elsata Xthelm 14. NAME OF HUSBAND OR WIFE Margaret C. Linne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charles J. Linne Jr. 937 Liggett Dr

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia & unknown etiol. INTERVAL BETWEEN ONSET AND DEATH

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Hypertensive Cardiovascular Disease

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) 792X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 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 6-13-53, 19____, to 7-5-53, 19____, that I last saw the deceased alive on 7-5-53, 19____ and that death occurred at 4:20A m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) _____ 22b. ADDRESS 1515 Lafayette Avenue 22c. DATE SIGNED 7-6-53

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE July 7, 1953 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. JUL 6 1953 REGISTRAR'S SIGNATURE J. Carl Smith M.D. 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl

2285 (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

Edmond M. Bennett

Licensed Embalmer No. 3024

P. O. Address.....

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

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