

No. 300
10. 48

FILED SEP 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29666

State File No.

BIRTH NO. _____ REG. DIST. NO. 371 PRIMARY REG. DIST. NO. 6260 Registrar's No. 18-

1. PLACE OF DEATH a. COUNTY <u>Webster</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural East Dallas</u>		c. CITY OR TOWN <u>Rural East Dallas</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>30 years</u>		e. STREET ADDRESS (If rural, give location) <u>Rt #4 Marshfield Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED a. (First) <u>Robert</u>		b. (Middle) <u>William</u>		c. (Last) <u>Lindenstruth</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 15 1954</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>April 18, 1875</u>		9. AGE (In years last birthday) <u>79</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer + Ret Army</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Webster County Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Henry James Lindenstruth</u>		13b. MOTHER'S MAIDEN NAME <u>Josephine Chaffin</u>		14. NAME OF HUSBAND OR WIFE <u>Josephine Lindenstruth</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>SPANISH AMERICAN War Service</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Mrs Josephine Lindenstruth Rt #4 Marshfield</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia,</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Cerebral Vascular accident</u>		<u>2 weeks</u>	
		DUE TO (c) <u>arteriosclerosis, generalized</u>		<u>10 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>		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 checked="" 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 1, 1954, to Aug 15, 1954, that I last saw the deceased alive on Aug 14, 1954, and that death occurred at 9:30P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. M. Macdonnell M.D.</u>		23b. ADDRESS <u>Marshfield Mo.</u>		23c. DATE SIGNED <u>8/16/54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 18 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CLIFTON Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Webster County Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>9-1-54</u>		REGISTRAR'S SIGNATURE <u>Opal M. Good</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Barber Funeral Home</u>		ADDRESS <u>Marshfield Mo</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

SEP 8 1954

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 Signature of Student Embalmer

Signed *Glen S. Williams*

Licensed Embalmer No. *465*

P. O. Address *Marshall*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.