

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28752

FILED SEP 6 1956

State File No. _____

7729

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived). If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri	
c. LENGTH OF STAY (in this place)		b. COUNTY PHELPS	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		c. CITY OR TOWN Vida	
		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) Route #1	

3. NAME OF DECEASED (Type or Print)	a. (First) George	b. (Middle)	c. (Last) Linden	4. DATE OF DEATH (Month) (Day) (Year) August 17, 1956
-------------------------------------	----------------------	-------------	---------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 23, 1882	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months Days Hours Mts.	IF UNDER 21 HRS.
----------------	---------------------------	---	-----------------------------------	---------------------------------------	---	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) employee	10b. KIND OF BUSINESS OR INDUSTRY Pioneer Cooprage	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	--

13a. FATHER'S NAME Charles Linden	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Ruth Linden-Vida Mo.
--------------------------------------	--------------------------------------	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY 494-10-2789	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ruth Linden - Vida, Mo.	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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subacute bacterial endocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
DUE TO (b) A) Bronchopneumonia Generalized arteriosclerosis with		Bronchopneumonia	
DUE TO (c) Arteriosclerotic heart disease coronary type		Arteriosclerotic heart disease coronary type	
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

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 <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 6-23-1956, to 8-17, 1956, that I last saw the deceased alive on 8-17, 1956, and that death occurred at 8:30A m., from the causes and on the date stated above.

23a. SIGNATURE John J. Leahy	23b. ADDRESS (Degree or title) M.D. St. John's Hospital	23c. DATE SIGNED 8-17-56
---------------------------------	--	-----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 21, 1956	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Ceme.	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
---	----------------------------	--	--

DA. REC'D BY LOCAL REG. AUG 21 1956	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE WACKER-HELDERLE	ADDRESS 3634 Gravois Ave.
--	--	---	------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 13 1958

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.....
Licensed Embalmer No. 264
P. O. Address St. Louis

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.