

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34740

STATE FILE NUMBER

FILED OCT 17 1956

Registration District No. 260 Primary Registration District No. 3041 Registrar's No. 196

1. PLACE OF DEATH a. COUNTY <u>MACON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MACON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CLARENCE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SAMARITAN Hosp</u>		Length of stay in lb <u>14 Hours</u>	d. STREET ADDRESS (If outside, give location) <u>CULVER HOTEL</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>THOMAS</u> Last <u>LINSON</u>			4. DATE OF DEATH Month <u>OCT</u> Day <u>6</u> Year <u>1956</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 19, 1879</u>		9. AGE (In years last birthday) Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HEAVY EGYPT CO</u>		11. BIRTHPLACE (City and state or country) <u>MO MACON COUNTY</u>	
13. FATHER'S NAME <u>GEORGE C. LINSON</u>			14. MOTHER'S MAIDEN NAME <u>MANNIE ATTEDERRY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MRS DONNA RAFFAUF HARVEY III</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACRANIAL HEMORRHAGE (1 mo.+)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>18 hours.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>HYPERTENSION</u>					<u>UNK.</u>
DUE TO (c) <u>ARTERIOSCLEROSIS</u>					<u>UNK.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>331X</u>			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>12-20-52</u> to <u>10-5-56</u> and last saw ^{him} alive on <u>10-5-56</u> Death occurred at <u>2 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Dean Rhull D.O.</u>			22b. ADDRESS <u>Clarence, MO</u>		22c. DATE SIGNED <u>10-11-56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>OCT 9, 1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MOBERLY MO</u>
24. FUNERAL DIRECTOR <u>Charles J. Steiner</u>		ADDRESS <u>Clarence Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-11-56</u>	26. REGISTRAR'S SIGNATURE <u>Walter M. Neely</u>

(Licensed Embalmer's Statement on Reverse Side)

Use only black ink or ribbon typewrite if possible. Coroner cannot certify to a death due to natural causes. Must be causally related.

MEDICAL CERTIFICATION

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RECEIVED
MACON COUNTY HEALTH DEPARTMENT
County File No.
Date Filed.....

10.16.56

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.....
Charles V. Green

Licensed Embalmer No. 48

P. O. Address. *Claxton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.