

Health, Welfare, Public Service
 300
 1-56
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED MAR 6 1957

4832
 STATE FILE NUMBER 750

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL		Length of stay in lbs. 66 years		d. STREET ADDRESS 618 TROOST (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEVI Middle E. Last LINZEY			4. DATE OF DEATH Month February Day 12 , Year 1957		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 12, 1890	9. AGE (In years last birthday) 67 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) Laborer		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) Warrensburg, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Harding Linzey		
14. MOTHER'S MAIDEN NAME s.r. Annie Linzey			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Address VA Hospital, Official Records, K. C. Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia					INTERVAL BETWEEN ONSET AND DEATH 4 2/3
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congestive heart failure					
DUE TO (c) Arteriosclerotic heart disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) 1			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____					
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 February 10, 1957 to February 12, 1957 and last saw him alive on February 12, 1957 . Death occurred at 10:40 AM _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE J. G. GIBBY, M.D. (Degree or title)			22b. ADDRESS VA Hospital, Kansas City, Mo.		22c. DATE SIGNED 2/13/57
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE 2/18/1957	23c. NAME OF CEMETERY OR CREMATORY Ft. Leavenworth Nat'l Cem.		23d. LOCATION (City, town, or county) (State) Ft. Leavenworth, Kansas
24. FUNERAL DIRECTOR L. E. Davis ADDRESS 2. E. Mo.		25. DATE RECD. BY LOCAL REG. 2-16-57		25. REGISTRAR'S SIGNATURE neva minshall	

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 Laudis A. Jackson

Licensed Embalmer No. 48

P. O. Address: K. C.

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.