

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041044  
STATE FILE NUMBER

FILED DEC 4 1958 Registration District No. 280 Primary Registration District No. 4423 Registrar's No. 81

300 4  
1-57

1. PLACE OF DEATH a. COUNTY <b>PLATTE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>PLATTE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WESTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>PLATTE CITY</b> <sup>0830</sup> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>MATTHEWS REST HOME</b>		Length of stay in lb <b>8 MOS.</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>B.</b> Last <b>LINNEY</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>13</b> Year <b>1958</b>	
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5. SEX <b>F</b>	6. COLOR OR RACE <b>WH.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 17, 1873</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (City and state or country) <b>KENTUCKY</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>JAMES H. HAGER</b>	13b. MOTHER'S MAIDEN NAME <b>RUANN WALSH</b>	14. NAME OF HUSBAND OR WIFE <b>OLIN A. LINNEY</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MRS. W. M. GIFFEE, PLATTE CITY, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hemorrhagic Leukemia + Arteriosclerosis</b>	
	DUE TO (c) <b>296X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease + Aortic Aneurysm</b>		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <b>9-10-58</b> to <b>11-13-58</b> and last saw her alive on <b>11-13-58</b> Death occurred at <b>5:00</b> P.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>C W Burkhead, M.D.</b>	22b. ADDRESS <b>Platte City, Mo</b>	22c. DATE SIGNED <b>11-14-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>11-16-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PLATTE CITY CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>PLATTE CITY, Mo.</b>
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24. FUNERAL DIRECTOR <b>ROLLINS &amp; MITCHELL</b>	ADDRESS <b>PLATTE CITY, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-14-58</b>	26. REGISTRAR'S SIGNATURE <b>Bphia Rollins</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

doctor, coroner, etc. must use only standard nomenclature in Part 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 Roland M. Giffey

Licensed Embalmer No. 4925

P. O. Address St. Louis, Mo.

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.