

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025264

FILED VS. AUG 14 1959 / 49

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

3672

STATE FILE NUMBER

DED

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		Length of stay in 1b 11 Years		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 Menorah Medical Center			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2837 Tracy Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Linebaugh Last _____				4. DATE OF DEATH Month 7 Day 27 Year 59				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Mar. 28, 1915 45	9. AGE (last birthday)	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Laborer			10b. KIND OF BUSINESS OR INDUSTRY Building Trade		11. BIRTHPLACE (City and state or country) Crowebury Kansas		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Joseph B. Linebaugh			13b. MOTHER'S MAIDEN NAME Mary F. Beadles			14. NAME OF HUSBAND OR WIFE Sarah Linebaugh		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO. 613-03-6479		17. INFORMANT Sarah Linebaugh 1616 Kensington Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia suffered							INTERVAL BETWEEN ONSET AND DEATH 14 1/2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. (b) during cave-in of earth								
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) Vena caval thrombosis with pulmonary emboli						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Wall of earth caved in on patient					
20c. TIME OF INJURY Hour _____ Month, Day, Year approx. 11:30 a.m. March 2, 1959			20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) 85th & Troost		20f. CITY, TOWN, OR LOCATION Kansas City	
				COUNTY Jackson		STATE MO.		
21. I attended the deceased from March 2, 1959 , to July 27, 1959 and last saw him alive on July 26, 1959 Death occurred at 12:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Jacob Kraft, M.D. (Degree or title)				22b. ADDRESS 701E 63rd St.			22c. DATE SIGNED July 28, 1959	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 29, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) Pittsburg, Kansas			
24. FUNERAL DIRECTOR MUEHLEBACH FUNERAL HOME 8800 Troost				25. DATE RECD. BY LOCAL REG. 7-29-59		26. REGISTRAR'S SIGNATURE Neia Trinchall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF JACOB TRAIL

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. T. Crowell

Licensed Embalmer No. 4905

P. O. Address H.C. M

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