

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-031694**

**FILED VS SEP 28 1959 53**

**3010**

**337**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cape Girardeau</b> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b> Length of stay in lb <b>13 days</b> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Southeast Mo. Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cape Girardeau</b> c. CITY OR TOWN <b>Cape Girardeau</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <b>136 Pearl Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JAMES</b> Middle <b>E.</b> Last <b>LINEBARGER</b>			<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>19</b> Year <b>1959</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>4/4/1877</b>	<b>9. AGE</b> (last birthday) <b>82</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>15</b> Hours <b></b> Min. <b></b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer, ret.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Street Dept.</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Friedheim, Missouri</b>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S.</b>		<b>13a. FATHER'S NAME</b> <b>William Linebarger</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Frances Hilderbrand</b>			
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ida May Linebarger</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>490-05-5884</b>			
<b>17. INFORMANT</b> <b>Mrs. Hollin Pender</b>		<b>Address</b> <b>Cape Gir., Mo.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>1. Hypertensive Cardio-Vascular disease</b> DUE TO (c) <b>(2) Arteriosclerosis (3) Anemia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>June 5th, 1959</u> to <u>Sept. 19, 1959</u> and last saw him <sup>xxx</sup> alive on <u>Sept. 18, 1959</u> Death occurred at <u>1:20 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Name or title) <i>Chas. M. Feter M.D.</i>			<b>22b. ADDRESS</b> <b>714 Broadway, Cape Girardeau, Mo.</b>		<b>22c. DATE SIGNED</b> <b>9/21/59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>Sept. 21, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Luthern Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Sedgewickville, Missouri</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Walther's Funeral Home</b>			<b>ADDRESS</b> <b>Cape Gir., Mo.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>9-24-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Leem Kasten</i>		

DOCUMENT V

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 29 1959

**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 William Lee Pound

Licensed Embalmer No. 4410

P. O. Address Cape Fear

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.