

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033441

FILED VS OCT 5 1959 310

3058

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Charles</b>		Length of stay in 1b <b>D.O.A.</b>	c. CITY OR TOWN <b>St. Charles</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1916 Easton Place</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>H.</b> Last <b>Linhoff</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>2</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Jun. 4, 1910</b>	9. AGE (last birthday) <b>49</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>28</b>	IF UNDER 24 HR Hours <b>—</b> Min. <b>—</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Planning Dept.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>McDonnell Aircraft</b>	11. BIRTHPLACE (City and state or country) <b>St. Charles, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Edward Linhoff</b>	13b. MOTHER'S MAIDEN NAME <b>Louise Stiegemeier</b>	14. NAME OF HUSBAND OR WIFE <b>Mathilda M. Ohmes</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>497-01-3520</b>	17. INFORMANT Address <b>Mrs. Harold Linhoff, St. Chas., 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>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b>	<b>Unknown</b>
	DUE TO (c) <b>Hypertensive Cardiovascular Disease</b>	<b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>—</b>		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 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.) <b>—</b>
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20c. TIME OF INJURY Hour <b>—</b> a.m. <b>—</b> p.m.	Month, Day, Year <b>—</b>
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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.) <b>—</b>	20f. CITY, TOWN, OR LOCATION <b>—</b>	COUNTY <b>—</b>	STATE <b>—</b>
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21. I attended the deceased from **August 31, 1959** to **October 2, 1959** and last saw him alive on **October 2, 1959**  
Death occurred at **8:30 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <b>Don Z. Randall, M.D.</b>	22b. ADDRESS <b>220 S. 6th St. Charles Mo.</b>	22c. DATE SIGNED <b>Oct. 2, 1959</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 5, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Barroness Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Charles Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>H.C. Dallmeyer &amp; Sons St. Charles, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Oct-2-59</b>	26. REGISTRAR'S SIGNATURE <b>Marcella Wilson</b>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

OCT 13 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 Frank R. Amal

Licensed Embalmer No. 483

P. O. Address St. Charles

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.