

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016291

FILED VS APR 20 1960

Registration District No. 257 Primary Registration District No. 5888 Registrar's No. 24

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Osage</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Gasconade</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Linn</u>		Length of stay in 1b <u>9 days</u>		c. CITY OR TOWN <u>Rosebud</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Linn Manor Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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 <u>John</u> Middle <u>Walter</u> Last <u>Linhardt</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1960</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-17-1891</u>	9. AGE (last birthday) <u>68</u>	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) <u>retired carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentering</u>		11. BIRTHPLACE (City and state or country) <u>Freedom, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Linhardt</u>			13b. MOTHER'S MAIDEN NAME <u>Sophia Kiso</u>			14. NAME OF HUSBAND OR WIFE <u>Amelia Lettmann Linhardt</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes WW I</u>			16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT Address <u>Henry Linhardt Rosebud, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) <u>Cerebral hemorrhage</u>							<u>14 days</u>	
DUE TO (c) <u>Arteriosclerosis, generalized</u>								
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		
19. WAS AUTOPSY PERFORMED? YES <input 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.)				
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 <u>4-7-60</u> p. to <u>4-16-60</u> and last saw ^{her} him alive on <u>4-14-60</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Samuel W. Baldwin D.D.</u>				22b. ADDRESS <u>Linn</u>			22c. DATE SIGNED <u>4-19-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>4-19-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Rosebud, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Gottenstroeter Funeral Home Owensville</u>				25. DATE RECD. BY LOCAL REG. <u>4-19-60</u>		26. REGISTRAR'S SIGNATURE <u>Miss. Clyde S. Maston</u>		
<u>Milton H. H. Winter</u> (Licensed Embalmer's Statement on Reverse Side)								

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 8 1960 SA

JUN 8 1960

MAY 25 1960

MAY 8 1960

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 Me _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Melford H H W

Licensed Embalmer No. 38

P. O. Address OWEN

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.