

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025646

FILED VS AUG 9 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 236

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Adair | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville, Mo. | | Length of stay in 1b 1 week | c. CITY OR TOWN Kirksville Mo. RR#4 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Laughlin Hospital | | 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 type="checkbox"/> |

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|--|-------------------------------|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Carl William Linder | | | 4. DATE OF DEATH Month Day Year 8/2/60 | | |
| 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 8/1/97 | 9. AGE (last birthday) 63 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during period of working life, even if retired) retired rural mail carrier | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Novinger, Adair Mo. | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME O.R. Linder | | 13b. MOTHER'S MAIDEN NAME Nancy Pinkerton Linder | | 14. NAME OF HUSBAND OR WIFE Leota Jones Linder | |
| 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. | 17. INFORMANT Address Mrs. Leota Jones Linder | | |

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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: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Toxemia | | | 3 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Acute nephrosclerosis | | 5 days |
| | DUE TO (c) dehydration and hemoconcentration due to diarrhea and vomiting. | | 5 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Auricular fibrillation and left auricular thrombus; Saddle thrombus of Aorta; Cerebral embolus | | | 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 |

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| 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.) | |
| 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 **July 26, 1960** to **Aug. 2, 1960** and last saw him alive on **Aug. 2, 1960**
Death occurred at **8:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>Subl. Amter</i> | (Degree or title) | 22b. ADDRESS Kirksville, Mo. | 22c. DATE SIGNED 8/3/60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 8/4/60 | 23c. NAME OF CEMETERY OR CREMATORY Maple Hills cemetery | 23d. LOCATION (City, town, or county) (State) Kirksville, Mo. |
| 24. FUNERAL DIRECTOR <i>Ray Sam Home Inc</i> | | ADDRESS Kirksville Mo | 25. DATE RECEIVED BY LOCAL REG. Aug. 4-60 |
| | | 26. REGISTRAR'S SIGNATURE <i>Dora W. Rathoff</i> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JACK A. AUXTER, D.O.

AUG 17 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 _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm H. Jackson

Licensed Embalmer No. 3954

P.O. Address Kershawville

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