

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043197

REGISTRATION DISTRICT NO. 310

PRIMARY REGISTRATION DISTRICT NO. 3058

REGISTRAR'S NO. 240

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Saint Charles</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Charles</u> Length of stay in 1b <u>life</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u> c. CITY OR TOWN <u>Saint Charles</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>726 South Benton</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>J. Linhoff, Sr.</u> Last <u></u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1885</u>	9. AGE (last birthday) <u>75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shoe cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and state or country) <u>Cottleville, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Frank Linhoff</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Toelle</u>	
14. NAME OF HUSBAND OR WIFE <u>Louise Stiegemeier</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>494-09-9139</u>	
17. INFORMANT <u>Edward Linhoff, Jr., St. Charles, 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>Pulmonary edema, acute</u> DUE TO (b) <u>Cardiac Failure, chronic due to Mitral insufficiency; cardiac dilatation</u> DUE TO (c) <u>Abscess of abdominal wall</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (But not related to the terminal disease condition given in PART I (a)) <u>Patient had small area of metastatic cancer in mesentery. Abscess of abdominal wall; not connected with old operative site or abdominal cavity.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>2-4 mo.</u> <u>2 weeks</u>	

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.)	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u>		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.) <u></u>	
20f. CITY, TOWN, OR LOCATION <u></u>		20g. COUNTY <u></u>		20h. STATE <u></u>	

21. I attended the deceased from <u>April 1960</u> to <u>Nov 27, 1960</u> and last saw him alive on <u>Nov 26, 1960</u> Death occurred at <u>7:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree, or title) <u>Russell Hilder, M.D.</u>		22b. ADDRESS <u>St Charles, Mo</u>	
22c. DATE SIGNED <u>Nov 28, 1960</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov 30, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		23d. LOCATION (City, town, or county) <u>Saint Charles, Mo.</u>		24. FUNERAL DIRECTOR <u>H.C. Dallmeyer & Sons, St. Charles, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>Nov. 30. 60</u>		26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>			

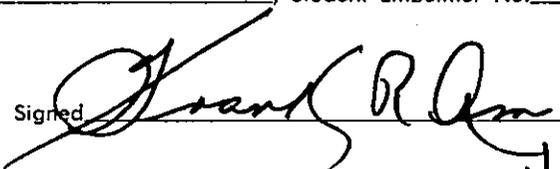
MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4

P. O. Address St. C.

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