

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033598

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registered at **FILED SEP 27 1962** Primary Registration District No. 3002 Registrar's No. 209

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1 0047				
2 0140				
3				
4 1				
5 2				
6				
7 0				
8 0				
9 433.1				
10				
11				
12 1-0	MEDICAL CERTIFICATION			
13 2-0				
	BY AFFIDAVIT OF			

USE BLACK INK OR TYPEWRITER RIBBON
Harey Green MD

1. PLACE OF DEATH a. COUNTY <u>Andrain</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>Annvasse</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>Andrain Co. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>none</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Luwina Boone Linton</u>			4. DATE OF DEATH Month Day Year <u>Sept. 19 1962</u>
5. SEX <u>Female</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>9-6-1879</u>
9. AGE (last birthday) <u>83</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>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Callaway County, Mo., U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Marcus Scholl</u>	
14. MOTHER'S MAIDEN NAME <u>Francis Fleming</u>		15. NAME OF HUSBAND OR WIFE <u>Alphonso Linton</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. SOCIAL SECURITY NO. <u>none</u>	18. INFORMANT <u>Mrs. John Cowan, Annvasse, 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>Mesenteric Thrombosis (gangrenal)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Embolus - Atrial Fibrillation</u>			<u>1 year</u>
DUE TO (c) <u>Generalized Arteriosclerosis</u>			<u>7 years</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>X</u>	
20c. TIME OF INJURY Hour <u>X</u> Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>X</u>	20f. CITY, TOWN, OR LOCATION <u>X</u>	COUNTY STATE
21. I attended the deceased from <u>Sept 16 - 62</u> , to <u>Sept 19 - 62</u> and last saw her <u>alive</u> on <u>Sept 19 - 62</u> . Death occurred at <u>Sept 15</u> <u>8 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Hans F O Bruen MD.</u>		22b. ADDRESS <u>Mexico, Missouri</u>	22c. DATE SIGNED <u>9/21/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-21-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Bloomfield Cemetery</u>	23d. LOCATION (City, town, or county) <u>New Bloomfield, Mo.</u>
24. FUNERAL DIRECTOR <u>Martin Funeral Home Fulton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 24 - 1962</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>

OCT 3 1962

Permit obtained
9-19-1962
B.H.

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Thomas M. Emmons

Licensed Embalmer No. 5064

P. O. Address Fulton, Mo

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.