MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Linn

Township Jefferson
or
Village
or
City (NO. St.; Ward)

Registration District No. 500 File No. 15145

Primary Registration District No. 3665 Registered No. 8

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Samuel Clifton Kuhn.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH: May 19 (Month) 1867 (Day), 1 (Year)

AGE: 48 yrs. 10 mos. 10 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Ohio

PARENTS

NAME OF FATHER: Samuel Kuhn,

BIRTHPLACE OF FATHER (City or town, State or foreign country): Pen.

MAIDEN NAME OF MOTHER: Martha Schuster

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Kuhn

(ADDRESS) Linneus Mo.

Filed 3/30/16 191__ F. M. Burke REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mch 29 (Month) (Day), 191 6 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 27, 191 6, to Mch 29, 191 6, that I last saw h[illegible] alive on Mch 27, 191 6 and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) ____ yrs. ____ mos. 2 ds.

Contributory (SECONDARY) Lagrippe

(Duration) ____ yrs. ____ mos. 10 ds.

(Signed) F. M. Burke M. D.

3/30/16 191__ (Address) Laclede

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Linneus Mo.

DATE OF BURIAL: 3/31/16 191__

UNDERTAKER: V. C. Travers

ADDRESS: Linneus Mo.

MISSOURI STATE BOARI
BUREAU OF VITAL ST
CERTIFICATE OF DE

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....
or
Village..... Primary Registration District No..... Registered No.....
or
City ..... (NO. ....., ... St.: ..... Ward)

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ....., 1..... (Day) ..... (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DE

DATE OF DEATH

..... (Month)

I HEREBY CERTIFY, that I atte

....., 191....., to.....

that I last saw h.....alive on.....

and that death occurred, on the date stated.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....

(Signed).....

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths fr
(1) Means of Injury; and (2) whether Accidental, Suicidal, o

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITU
RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yr

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DA
UNDERTAKER	ADI

occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Automobile factory*.

pneumonia, *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*Anaemia*" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.),