

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED JUN 7 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JUN 7 1940
Registration District No. 408

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18702

State File No. _____

Primary Registration District No. 3020

Registrar's No. 111

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
818 Syracuse
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 24 years years, months or days)

3. (a) PRINT FULL NAME WILLIAM D. LINDER
3. (b) If veteran, name war no
3. (c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Linder
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 1, 1872
(Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 18
If less than one day _____ hr. _____ min.

9. Birthplace Wheeler County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Quartermaster

11. Industry or business _____
12. Name John Linder
13. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Thelma Reed
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. W. D. Linder
(b) Address 818 Syracuse - Carthage

17. (a) Burial (b) Date thereof May 22, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery
18. (a) Signature of funeral director Ernest Mortuary
(b) Address Carthage, Mo.

19. (a) May 24, 1940 (b) E. J. McEntire, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Carthage
(If outside city or town limits, write "RURAL")
(d) Street No. 818 Syracuse
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 19
year 1940 hour 2 minute P. M.
21. I hereby certify that I attended the deceased from 7-26 7, 1940
_____, 19____, to May 19, 1940
that I last saw him alive on May 19, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Chr nephritis - Indefinite
Due to _____
Due to _____
Other conditions Uremia - 121
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
865
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Norman E. Boyd (M. D. or other)
Address Carthage Mo Date signed May 24

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed P. W. K. [Signature]

Licensed Embalmer No. 814

P. O. Address Carthage, 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 this body is not embalmed, above space should be left blank.