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X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32129

OCT 3 1940

Registration District No. 349 Primary Registration District No. 3018 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 512 E Lincoln St (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 59

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Henry
(c) City or town Clinton (If outside city or town limits, write "RURAL")
(d) Street No. 512 E Lincoln St (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ida Mae Linebeck
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife John Linebeck
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased 5 (Month) 2 (Day) (Year)

8. AGE: Years 59 Months 4 Days 27 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John Sella
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Elizabeth Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Oscar Raef
(b) Address Clinton Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 1 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Hopewell
18. (a) Signature of funeral director Fred C Wilkinson
(b) Address Clinton Mo
19. (a) (Date received local registrar) (b) Dr J R Hampton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29 year 1940 hour 10 minute 30 A M.

21. I hereby certify that I attended the deceased from March 1, 1940, to Sept 29, 1940; that I last saw her alive on Sept 28, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death. Sarcoma in left inguinal gland	1 M
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Tumor removed Laboratory findings sarcoma	
Of autopsy none	

PHYSICIAN 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature G L Walker (M. D. or other) M D
Address Clinton Mo Date signed 9-30-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 70-40-1488
Date Filed 16-11-40

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 Fred W Wilkerson

Licensed Embalmer No. 2478

P. O. Address Clinton Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

o. 2B
-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32129

Registration District No. 347 Primary Registration District No. 3018 Registrar's No.

FILED DEC 14 1940

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

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

3. (a) PRINT FULL NAME Ida Mae Linebeck
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) 11 (Day) 5 (Year) 1881

8. AGE: Years 59 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Oct-8-1940 (Date received local registrar) (b) Dod J. R. Honeyblue (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work?
(e) Means of injury

23. Signature G. S. Walker (M. D. or other)
Address Clinton Mo. Date signed