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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 8 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41358

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4751

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

1. PLACE OF DEATH:

(a) County Jackson 1

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Research Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 hrs - 45 min (Specify whether
In this community 13 hrs - 45 min years, months or days)

2. USUAL RESIDENCE OF DECEASED: 0

(a) State Missouri (b) County Lafayette

(c) City or town Higginsville
(If outside city or town limits, write "RURAL")

(d) Street No. 407 West Talmadge
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Twyla Jean Rinne

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 .....

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased 12 (Month) 13 (Day) 40 (Year)

8. AGE: Years | Months | Days | If less than one day 13 hrs. 45 min.

9. Birthplace Kansas City (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation ✓ 0

11. Industry or business ✓

FATHER
12. Name Owen Benjamin Rinne 0
13. Birthplace Higginsville (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Helen Amelia Klein
15. Birthplace Higginsville (City, town, or county) Mo (State or foreign country)

16. (a) Informant Owen Benjamin Rinne
(b) Address Higginsville

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-13-40 (Month) (Day) (Year)
(c) Place: burial or cremation Higginsville Mo

18. (a) Signature of funeral director Haefer & Monnenhagen
(b) Address Higginsville Mo

19. (a) 12/13/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day thirteenth year 1940 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from 4:15 a.m. 12/13, 1940, to 4:30 P.M. 12/13, 1940 that I last saw her alive on 12/13, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral pulmonary massive collapse

Due to prematurity plus toxicity of pre-eclampsia pf mother

Due to

Other conditions 159
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy - Consolidation of both lungs - never aerated to any extent

Duration

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 E. A. Wilkinson, M.D. (M. D. or other)

Address 1103 Grand Ave Date signed 12/13/40

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.