

FILED JUN 26 1946

Registration District No. 291

Primary Registration District No. 1442

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph
 (b) City or town Higbee Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (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 About 7yrs
years, months or days

3. (a) PRINT FULL NAME Mrs Linnie Todd

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased Mar. 10 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>2</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace Boone Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

12. Name Dont Know

13. Birthplace Dont Know
(City, town, or county) (State or foreign country)

14. Maiden name Dont Know

15. Birthplace Dont Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mr Steve Todd

(b) Address Paris Mo

17. (a) Burial (b) Date thereof May 30 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hinton Mo.

18. (a) Signature of funeral director Joe W Burton

(b) Address Higbee Mo

19. (a) _____ (b) J. W. Wain
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
 (c) City or town Higbee Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28
 year 1946 hour 8 minute 15 P.M.

21. I hereby certify that I attended the deceased from December 1945 to May 1946
 that I last saw her alive on May 27
 and that death occurred on the date and hour stated above.

Immediate cause of death Gastric Carcinoma

Due to _____

Due to _____

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

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? _____

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

23. Signature V. J. Robinson (M. D. or other) D.O.

Address Higbee, Mo. Date signed 5-30-46

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

MOTHER FATHER

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 *A. W. Guernon*

Licensed Embalmer No. *3978*

P. O. Address *Glasgow 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, fact should be so stated above.

Registration District No. *890* Primary Registration District No. *4442*

1. PLACE OF DEATH:

(a) County *Randolph*

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

(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

3. (a) PRINT FULL NAME *Linnie Todd*

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 *wid*

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

7. Birth date of deceased *Mar 10*
(Month) (Day) (Year)

8. AGE: Years *79* Months _____ Days _____ If less than one day _____
hr. _____ min. _____

9. Birthplace _____
(City, town, or county) (State or foreign country) *MO*

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) *J. H. Linn*
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year *1946* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____
that I last saw him _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(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? _____

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

21185