

S. No. 2
M-5-43
5-17-39
I X36671

33783

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 6 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 4505

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution St. Lukes Hospital
(d) Length of stay: In hospital or institution 2 da. 12 hr.
In this community 2 da. 12 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 4012 Warwick Blvd.
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Linda Lee Sprinkle
(b) If veteran, name war no
(c) Social Security No. none
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced O
6. (c) Age of husband or wife if alive - years
7. Birth date of deceased 10 15 1946

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month 10 day 18 year 1946 hour 2 minute 5 A.M.
21. I hereby certify that I attended the deceased from 10-15-46 to 10-18-46 that I last saw her alive on 10-18 1946 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
7 12 hr. 26 min.

Immediate cause of death: Pneumonia acute
Congestive heart failure
(patent interventricular septum)
Duration 36 hrs
Due to _____
Other conditions (Include pregnancy within 3 months of death) 108
Major findings: Of operations _____
Of autopsy As above

9. Birthplace Kansas City Missouri
10. Usual occupation infant

11. Industry or business _____
12. Name Cigero Chester Sprinkle
13. Birthplace Toccoa Georgia
14. Maiden name Dorothy Louise Lee
15. Birthplace Milledgeville Georgia

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

16. (a) Informant Mr. C.C. Sprinkle
(b) Address 4012 Warwick Blvd
17. (a) Cremation (b) Date thereof 10 18 1946
(c) Place: burial or cremation St. Lukes Hospital
18. (a) Signature of funeral director St. Lukes Hospital
(b) Address 44th & Mill Creek
19. (a) 10-26-46 (b) Ethelaine Hoffman

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(e) Means of injury _____
23. Signature _____ M.D. or other _____
Address 1500 Thompson Bldg date signed 23 Oct '46

(Licensed Embalmer's Statement on Reverse Side)

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.....

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, fact should be so stated above.