

36/

BIRTH NO. 443 REG. DIST. NO. 114 PRIMARY REG. DIST. NO. 4186 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sullivan		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sullivan, Mo.	
c. LENGTH OF STAY (in this place) North		d. STREET ADDRESS (If rural, give location) Sullivan, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Sullivan, Mo			

3. NAME OF DECEASED (Type or Print) Linda Kay Whitmer	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Sept 26 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) None	8. DATE OF BIRTH 12-7-48	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS. Days 19
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY Child	11. BIRTHPLACE (State or foreign country) Mo. North Side Hosp. Sullivan	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Allen Whitmer	13b. MOTHER'S MAIDEN NAME Margaret Clark	14. NAME OF HUSBAND OR WIFE Child
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Allen Whitmer, Sullivan, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral palsy - spastic		Life
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Traumatic birth injury		Life
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			351X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 1950, to 9-26, 1950, that I last saw the deceased alive on 9-26, 1950, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE C. Practor M.D.	23b. ADDRESS Sullivan Mo	23c. DATE SIGNED 9/27/1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sent 27-	24c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery	24d. LOCATION (City, town, or county) Sullivan, Mo.
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DATE REC'D BY LOCAL REG. 9-27-1950	REGISTRAR'S SIGNATURE C. Practor 97	25. FUNERAL DIRECTOR'S SIGNATURE Mrs. L. P. Stoffer	ADDRESS Sullivan
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

File No. _____
DISTRICT HEALTH OFFICE No. 4

OCT - 3 1950

RECEIVED

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed *Phos. S. Shaffer*

Signed _____
Student Embalmer

Licensed Embalmer No. 2692

P. O. Address Sullivan 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.