

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6225

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo** (No. **1730 Franklin Ave**)

File No. **1410**

Registered No. **1410**

St. Ward

2. FULL NAME *William Link*

(a) Residence. No. **1730 Franklin Ave**, St. **25** Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Don't know.*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *About 54*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Barber*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Ills.* (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Joseph Link*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Don't know* (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Don't know*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Don't know* (STATE OR COUNTRY)

14. INFORMANT *Anna Link* (Address) *1730 Franklin Ave*

15. FILED **FEB 10 1927** *Mar 6 Starks*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb. 7 1927*

17. I HEREBY CERTIFY That I attended deceased from *Jan 31* to *Feb 7* 19*27* that I last saw him alive on *Jan 6 1927* and that death occurred, on the date stated above, at *7:40 PM* am.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Bright's Disease
1326
29 B (duration) yrs. mos. ds.

CONTRIBUTORY *Alcoholism Chronic* (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *Samuel J. Neal*, M. D.

208, 19*27* (Address) *1900 Madison*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *National Cem.* DATE OF BURIAL *Feb. 10 1927*

20. UNDERTAKER *By Leidner Ind. Co* ADDRESS *1417 N. Market St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

