

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

JUN 12 1935

17981

1. PLACE OF DEATH

County.....  
Township.....  
City *St. Louis*

Registration District No. **791**  
Primary Registration District No. **1003**  
(No. *5247<sup>e</sup> Galien Ave*)

File No.....  
Registered No. **4301**  
St. .... Ward)

2. FULL NAME

*Frank X. Link*  
(a) Residence, No. *5247<sup>e</sup> Galien Ave.*, Ward. *7*

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) <i>Mary Stagedorn</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Nov 1<sup>st</sup> 1870</i>		
7. AGE YEARS <i>64</i>	MONTHS <i>5</i>	DAYS <i>10</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>City water dept.</i>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 10*, 19*35*

22. I HEREBY CERTIFY, That I attended deceased from *Feb. 33* 19*35* to *May 10*, 19*35*

I last saw him alive on *May 10*, 19*35* Death is said to have occurred on the date stated above, at *8:45* p.m.

The principal cause of death and related causes of importance were as follows:

*Hemiplegia*

*Chr. Suppuration*

Date of onset

930

Name of operation..... Date of.....  
What test confirmed diagnosis? *clinical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....  
Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *No*  
If so, specify.....  
(Signed) *Just H. Perce* M. D.  
(Address) *573<sup>1/2</sup> W. Elm*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis*

13. NAME *Joe Link*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

17. INFORMANT (ADDRESS) *Mary Link 2449<sup>e</sup> Robin Ave*

18. BURIAL, CREMATION, OR REMOVAL  
PLACE *St. Peter & Paul* DATE *May 14*, 19*35*

19. UNDERTAKER (ADDRESS) *Parsonsburg Wood Co 4740<sup>th</sup> St. St. Louis Mo*

20. FILED *MAY 13 1935* 19 *J. H. Bruback* Registrar.

