

SEP 10 1937

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

29542
Do not use this space.

1. PLACE OF DEATH -

(a) County.....
(b) Township.....
(c) City St. Louis
(d) Street No. De Paul Hospital
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

791
1003

Registered No. 8175

2. PRINT FULL NAME George H. Linkman

(a) Residence, No. 4883a Farlin Avenue St. 7
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 4, 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
62 1 26

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Accountant
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

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

13. NAME Charles F. Linkman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Charlotte Blomberg

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) usau Linkman 4883 a Farlin Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Salem DATE Sept. 1, 1937

19. FUNERAL DIRECTOR (ADDRESS) Math. Hermann & Son 2161 East Fair Avenue

20. FILED (ADDRESS) J. J. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 29 1937

22. I HEREBY CERTIFY, That I attended deceased from 3-9-37, 1937, to 8-29-37, 1937.
I last saw him alive on 8-29-37, 1937. Death is said to have occurred on the date stated above, at 2:10 P. M.
The principal cause of death and related causes of importance were as follows:

Arctic resuscitation.
none

Name of operation none Date of none
What test confirmed diagnosis? Was there an autopsy?

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 W. H. Sporenman, M. D.
(Signed) W. H. Sporenman, M. D.
(Address) 1506 87/2 Louis

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.

9669

OCCUPATION FATHER MOTHER

AUG 31 1937

STATEMENT BY LICENSED EMBALMER

I, William G. Buchholz, Licensed Embalmer No. 2110

hereby certify that the body recorded on the reverse side of this certificate was embalmed by William G.

Buchholz, L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed William G. Buchholz

Licensed Embalmer No. 2100

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.)