No. 2
-13-40
-17-39
I X23159

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33062

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 1808

FILED OCT 23

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 days (Specify whether years, months or days)
In this community 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
(d) Street No. 422 Queen Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Ruth Link
3. (b) If veteran, name war No.
3. (c) Social Security No. None
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife William Roy Link
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased June (Month) 1 (Day) 1893 (Year)

8. AGE: Years 47 Months 3 Days 22 If less than one day ____ hr. ____ min.

9. Birthplace Unknown (City, town, or county) Kansas (State or foreign country)
10. Usual occupation housewife
11. Industry or business

MOTHER FATHER
12. Name Charles Webster
13. Birthplace Unknown (City, town, or county) Kansas (State or foreign country)
14. Maiden name Josephine Pennel
15. Birthplace Unknown (City, town, or county) Kansas (State or foreign country)

16. (a) Informant Mr. Roy Link
(b) Address 422 Queens St. Web. Groves
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-40 (Month) (Day) (Year)
(c) Place: burial or cremation Kirkwood, Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.
19. (a) SEP 24 1940 (Date received local registrar) (b) R. R. Meyer M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23 year 1940 hour 2 minute :40 P. M.
21. I hereby certify that I attended the deceased from 8-27-40, 19..., to 9-23-40, 19...; that I last saw her alive on 9-23-40, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Thrombosis?	4 days
Due to: Coronary Occlusion	—
Due to: Pulmonary Congestion	4 days
Due to: Myocardial Insufficiency	
Other conditions (Include pregnancy within 3 months of death): Chronic cholecystitis Cholelithiasis	12 yr

Major findings:
Of operations: Chronic Diff. of Gall Bladder & Stones on G.B. & Common Duct
Of autopsy: Patent Foramen Ovale; Pulmonary Congestion

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

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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature James David M.D. (M. D. or other)
Address St. Louis County Hosp. Date signed 9/24/40

(Licensed Embalmer's Statement on Reverse Side)

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 Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.