

FILED AUG 20 1945 STANDARD CERTIFICATE OF DEATH

State File No. 27845

Registration District No. 192

Primary Registration District No. 5707

Registrar's No. 14

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Tiff City, Mo. *the Miller*
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Mo.
In this community 3 Mo.
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Okla. (b) County Delaware
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph Elias Link

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mamie Link 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased Jan. 13 1874
(Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace Stella, Missouri (City, town, or county) (State or foreign country) 0

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name John Link
13. Birthplace Unknown
14. Maiden name Lucretia Sunderlark
15. Birthplace Rhode Island
(City, town, or county) (State or foreign country)

16. (a) Informant Mamie Link

(b) Address Tiff City Mo.

17. (a) Burial (b) Date thereof July 27, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Tom Calvoche

(b) Address Jay Owen

19. (a) 8-9-45 (b) Dijonius Bush
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
year 1945 hour 11:45 minute 0 M.

21. I hereby certify that I attended the deceased from July, 1944, to July, 1945;
that I last saw him alive on Nov 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Ischemic Heart Disease

Due to 2

Due to ✓

Other conditions ✓
(Include pregnancy within 3 months of death)

Major findings: ✓
Of operations 8/26
Of autopsy _____

Duration _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature Shirley C. ... (M. D. or other) _____
Address Springfield City Mo Date signed July 28, 1945

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

RECEIVED

District Health Officer No. 6;

District File Number 845-865

Date Filed AUG 13 1945

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 Jain Clarke

Licensed Embalmer No. 993

P. O. Address Jay, Okla.

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.