

S. No. 2
 00M-5-43
 Rev. 5-17-39
 I X36871

State File No. 10035
 Registrar's No. 10035

FILED NOV 29 1945
 318

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 4844 Sigel Ave.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME John Link
 3. (b) If veteran, name war _____
 3. (c) Social Security No. 498-05-4076

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Josephine
 6. (c) Age of husband or wife if alive 71 years
 7. Birth date of deceased Oct. 24 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>0</u>	<u>25</u>	hr. _____ min. _____

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation City Sanitarium

11. Industry or business Unknown

12. Name _____
 13. Birthplace _____
 14. Maiden name Unknown
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Josephine Link
 (b) Address 4844 Sigel Ave.

17. (a) Burial (b) Date thereof Nov. 22, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Wacker-Heldale
 (b) Address 3634 Gravois Ave.

19. (a) NOV 20 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 4844 Sigel Ave.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov. day 19
 year 1945 hour 2 minute 25 P. M.

21. I hereby certify that I attended the deceased from Sept. 15, 1945 to Nov. 19, 1945
 that I last saw him alive on Nov. 18, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death: Valvular Heart Disease

Due to _____
 Due to _____
 Other conditions: _____
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____

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) (c) Means of injury

23. Signature Clay Oliver (M. D. or other) _____
 Date signed 11/20/45

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

100
 17
 9

000
 217
 9
 0

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. R. Link, Mo

