

FILED MAR 21 1947

Registration District No. 338

Primary Registration District No. 6148

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Bloomfield Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard ¹⁰³

(c) City or town Bloomfield Rural ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) ⁰

(e) Citizen of foreign country? _____ (Yes or No) ⁰
If yes, name country _____

3. (a) PRINT FULL NAME DANIEL FRANKLIN LINK

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 16, 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

84	1	9	hr. _____ min.
----	---	---	----------------

9. Birthplace Stoddard co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Aaron Link

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Martha Roberts

15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Franklin Link

(b) Address Bloomfield, Mo. Rural

17. (a) Burial (b) Date thereof 2-28-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Link cemetery

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) 3-14-1947 (b) Rose Weber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 25th
year 1947 hour 11:55 minute _____ P. _____ M.

21. I hereby certify that I attended the deceased from Nov. 9 - 1946 to Feb. 25 - 1947
that I last saw him alive on Feb. 25 - 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Double Labor Pneumonia

Due to Chronic Myocarditis

Due to _____

Other conditions 108
(Include pregnancy within 3 months of death)

Major findings: Supra Pubic brain

Of operations _____

Of autopsy No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Med

(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 _____

23. Signature S. S. Hantz (M. D. or other) ⁰

Address _____ Date signed 2/24/47

Duration

2 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

0003

RECEIVED
District Health Office No. 2,
District File Number 347-365
Date Filed 3-17-47

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 Juan B. Cooper
Licensed Embalmer No. 4119
P. O. Address Bloomfield, Mo.

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.