

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21528

FILED JUL 14 1948

3063

Registrar's No. 1547

Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:
(a) County St. Louis County
(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 2 DAYS
(Specify whether
In this community LIFE
years, months or days)

3. (a) PRINT FULL NAME JOSIE LINKOGEL
3. (b) If veteran, name war No
3. (c) Social Security No. No 2

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, divorced, married DIVORCED
6. (b) Name of husband or wife JOHN LINKOGEL
6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased: APRIL 19 1883
(Month) (Day) (Year)

8. AGE: Years 65 Months 2 Days 2
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name PHILLIP TIEM
13. Birthplace 9
(City, town, or county) (State or foreign country)
14. Maiden name LOUISE
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant HOSPITAL RECORDS
(b) Address St. Louis County Hospital
17. (a) Cremation (b) Date thereof 6-13-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crem.
18. (a) Signature of funeral director Collier Funeral Home
(b) Address 10123 N. Charles Rd
6-22-48 (c) Paul J. Sharp MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County St. Louis Co.
(c) City or town OVERLAND 96
(If outside city or town limits, write "RURAL")
(d) Street No. 3314 WOODSON 13
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 21
year 1948 hour 6 minute 25AM
21. I hereby certify that I attended the deceased from JUNE 19 1948 to JUNE 21 1948
that I last saw her alive on JUNE 21 1948
and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinomatosis

Due to Carcinoma (epidermoid) of 14.7 Cervix

Due to 4800

Other conditions (include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy
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
23. Signature B. Smith Jr. M.D. (M. D.)
Address 6019 BREXWOOD DR Date signed 6/21/48

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address Overland, 14

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

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

July
1547

Registration District No. 317

Primary Registration District No. 3063

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis Co.
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 _____)
years, months or days

3. (a) PRINT FULL NAME

Jessie Linkogel

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced div

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

7. Birth date of deceased April 19 1881
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days 2 If less than one day hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation Stenographer

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 15 year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SLIPPED

TEMPORARY

MOTHER FATHER

