

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 2 1950

State File No. ....

3627

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

|                                                                                         |                                                   |                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>                                           |                                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> | c. LENGTH OF STAY (in this place) <u>7 years.</u> | c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>                                                |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>21 W 73 Terrace</u>                          |                                                   | d. STREET ADDRESS (If rural, give location) <u>21 W 73<sup>rd</sup> Terrace</u>                                                        |  |

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| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>LIDA</u> b. (Middle) <u>BELLE</u> c. (Last) <u>LINK</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 23/50</u> |
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|                 |                           |                                                                       |                                     |                                                                                                                          |
|-----------------|---------------------------|-----------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Nov 8, 1870</u> | 9. AGE (In years last birthday) <u>79</u> IF OVER 1 YEAR: Months _____ Days _____ IF UNDER 1 HR.: Hours _____ Min. _____ |
|-----------------|---------------------------|-----------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------|

|                                                                                                              |                                            |                                                                 |                                            |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------------------------------|--------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (State or foreign country) <u>Edgar Co, Ill.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------------------------------|--------------------------------------------|

|                                        |                                                 |                                              |
|----------------------------------------|-------------------------------------------------|----------------------------------------------|
| 13a. FATHER'S NAME <u>George Athey</u> | 13b. MOTHER'S MAIDEN NAME <u>Sarah Mulligan</u> | 14. NAME OF HUSBAND OR WIFE <u>Nate Link</u> |
|----------------------------------------|-------------------------------------------------|----------------------------------------------|

|                                                                                                                    |                                   |                                                                                   |
|--------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. <u>no</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Wendell Link</u> ADDRESS <u>Piper, Kans.</u> |
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| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION                                                                                                                                                                     |  | INTERVAL BETWEEN ONSET AND DEATH |
|                                                                                                                                                                                                                                 | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>                                                                                                         |  | <u>1 wk.</u>                     |
|                                                                                                                                                                                                                                 | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Sclerosis Arteriosclerosis</u><br>DUE TO (c) _____ |  | <u>Years</u>                     |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                                                                                             |                                                                                                                                                                                           |  | <u>33 1/2</u>                    |

|                              |                                        |                                                                                  |
|------------------------------|----------------------------------------|----------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------|----------------------------------------|----------------------------------------------------------------------------------|

|                                                |                                                                                                |                                                                   |
|------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____ |
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|                                                                |                                                                                                        |                                  |
|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____ | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |
|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------|

22. I hereby certify that I attended the deceased from Aug 17, 1950, to Aug 30, 1950, that I last saw the deceased alive on Aug 23, 1950, and that death occurred at 10:12 p.m., from the causes and on the date stated above.

|                                                                      |                                      |                                 |
|----------------------------------------------------------------------|--------------------------------------|---------------------------------|
| 23a. SIGNATURE <u>George K. Landis</u> (Degree or title) <u>M.D.</u> | 23b. ADDRESS <u>1630 Prof. Bldg.</u> | 23c. DATE SIGNED <u>8/24/50</u> |
|----------------------------------------------------------------------|--------------------------------------|---------------------------------|

|                                                          |                            |                                                   |                                                                            |
|----------------------------------------------------------|----------------------------|---------------------------------------------------|----------------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>Aug 24/50</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Masonic</u> | 24d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo</u> |
|----------------------------------------------------------|----------------------------|---------------------------------------------------|----------------------------------------------------------------------------|

|                                         |                                                |                                                                                           |
|-----------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------|
| DATE REC'D BY LOCAL REG. <u>8-24-50</u> | REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Virgil Hope</u> ADDRESS <u>Excelsior Springs, Mo.</u> |
|-----------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------|

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Virgil Hope.....

Licensed Embalmer No. 3950.....

P. O. Address Exelior Springs.....  
Mo

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.