

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 20 1957

State File No. **16248**

S. No. 300
V. 10-48

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>538</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>2 1/2 Hours</u>		c. CITY OR TOWN <u>St. Joseph</u>		d. Is Residence within limits of a city incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u>				3. STREET ADDRESS (If rural, give location) <u>1011 Edmond St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fredrick</u> b. (Middle) <u>C.</u> c. (Last) <u>Linck</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 14-1957</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb 24-1878</u>	
9. AGE (In years last birthday) <u>84</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Jackson Co Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13a. FATHER'S NAME <u>John Linck</u>		13b. MOTHER'S MAIDEN NAME <u>un known</u>		14. NAME OF HUSBAND OR WIFE <u>AMY LINCK.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frank Linck Ruridale mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Stokes Adams Syndrome</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4330	
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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 <u>5/13, 1957</u> , to <u>5/14, 1957</u> , that I last saw the deceased alive on <u>5/14, 1957</u> , and that death occurred at <u>4:20 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Scott Jensen M.D.</u>				23b. ADDRESS <u>St. Joseph, Mo. 510 Cotley Bldg</u>		23c. DATE SIGNED <u>5/14/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>MAY 14-1957</u>		24c. NAME OF CEMETERY OR CREMATORIUM <u>SAVANNAH</u>		24d. LOCATION (City, town, or county) (State) <u>SAVANNAH MO</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>May 16, 1957</u>		REGISTRAR'S SIGNATURE <u>Gather M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Breit Funeral Home SAVANNAH MO</u>			

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

485

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.....
Signature of Student Embalmer

Signed *E. C. Breet*.....

Licensed Embalmer No. *2657*

P. O. Address *Lawrence, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.