Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001927

STATE FILE NUMBER

FILED JAN 20 1959

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 4

1. PLACE OF DEATH
a. COUNTY Lafayette
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Lexington — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Memorial — Length of stay in 1b I day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Lafayette
c. CITY OR TOWN Higginsville 0541 0 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) East side — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Mary Middle Keithly Last Link

4. DATE OF DEATH Month January Day 9 Year 1959

5. SEX female

6. COLOR OR RACE white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH 4-29-1899

9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (City and state or country) O'Fallon, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Joseph Keithly

13b. MOTHER'S MAIDEN NAME Ellen Palardy

14. NAME OF HUSBAND OR WIFE Adolph H. Link

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 487-34-7031

17. INFORMANT Adolph H. Link — Address Higginsville, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C.V.A. — INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Metastatic Ca of Uterus — Known 6 mo.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 174X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3-29-57, to 1-9-59 and last saw her/him alive on 1-9-59
Death occurred at 7:15 pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wilbur E. Fulkerson M.D.

22b. ADDRESS Higginsville Mo

22c. DATE SIGNED 1-12-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 1-12-1959

23c. NAME OF CEMETERY OR CREMATORY City

23d. LOCATION (City, town, or county) Higginsville (State) Mo.

24. FUNERAL DIRECTOR F. A. Hoefer — ADDRESS Higginsville, Mo.

25. DATE RECD. BY LOCAL REG. 1-16-59

26. REGISTRAR'S SIGNATURE [signature]

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Forest R. Haefer

Licensed Embalmer No. 4801

P. O. Address Higginsville, 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.