

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

210883

59-042155

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4 days	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4471 Olive St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First John Middle Link Last	4. DATE OF DEATH Month November Day 20 Year 1959
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5. SEX Male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/12/1887	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender	10b. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME John Link	13b. MOTHER'S MAIDEN NAME Anna Ramping	14. NAME OF HUSBAND OR WIFE Grace Link
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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. 478-18-7024	17. INFORMANT Address Grace Link, 4471 Olive St.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Septicemia		24 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Ac. Glomerulonephritis	4 days
	DUE TO (c) Chronic Cystitis 605+	4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis Obliterans - 4 days.	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from **11-16-59** to **11-20-59** and last saw her/him alive on **11-20-59**
Death occurred at **11:05 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John W. Beckham, M.D.	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 11/23/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-24-59	23c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchyard	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. NOV 24 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Guy Wilkerson*

Licensed Embalmer No. 307

P. O. Address *...*

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.