

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**60-012268**

STATE FILE NUMBER

FILED VS. MAR 23 1960 316

Primary Registration District No. 3061 Registrar's No. 111

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Francois</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Flat River</b>		Length of stay in 1b <b>2 5 yrs.</b>		c. CITY OR TOWN <b>Flat River</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6 High St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Thomas Jackson Link</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>18</b> Year <b>1960</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-30-1878</b>		9. AGE (last birthday) <b>82 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Power House Oper.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Joseph Lead Co.</b>		11. BIRTHPLACE (City and state or country) <b>Desloge, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>James Link</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Light</b>			14. NAME OF HUSBAND OR WIFE <b>Ida Mary Link</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>493-03-8967</b>		17. INFORMANT <b>Margrin Link, Leadwood, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>arteriosclerosis; coronary artery</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>instantaneous</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <b>artery sclerosis heart disease</b> <b>atherosclerosis</b>						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			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)					
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	
21. I attended the deceased from <b>Nov 1959</b> to <b>Mar. 18-60</b> and last saw <sup>her</sup> him alive on <b>2-15-66</b> Death occurred at <b>1-14</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>W D Gatch M D</b>				22b. ADDRESS <b>Desloge Mo</b>				22c. DATE SIGNED <b>3-18-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-20-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Caledonia</b>			23d. LOCATION (City, town, or county) (State) <b>Caledonia, Missouri</b>		
24. FUNERAL DIRECTOR <b>Bert L. Boyer, Leadwood, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Mar. 18, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Gather P. Dillhoff</b>			

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 Bert L. Boyer

Licensed Embalmer No. 3445

P. O. Address Leadwood

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.