

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037854

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 245 Primary Registration District No. 3041 Registrar's No. 114

FILED OCT 16 1961

1. PLACE OF DEATH a. COUNTY <u>Newton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Neosho</u>		c. CITY OR TOWN <u>Seneca</u>	
Length of stay in lb <u>6 hrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sale Memorial Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Seneca</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>Fredric</u> Last <u>Link</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1961</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, '11</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u>	IF UNDER 24 HR Hours <u>16</u> Min. <u>00</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Terminal manager</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Line</u>	11. BIRTHPLACE (City and state or country) <u>Nebraska</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Fred Link</u>	13b. MOTHER'S MAIDEN NAME <u>Rose Hughes</u>	14. NAME OF HUSBAND OR WIFE <u>Dorothy</u>
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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) <u>Yes WWII</u>	16. SOCIAL SECURITY NO. <u>WWII</u>	17. INFORMANT Address <u>Mrs. Dorothy Link, Seneca, Mo</u>
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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: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 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.)
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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 <u>1959</u> to <u>Oct 7, 1961</u> and last saw him alive on <u>Oct 7, 1961</u> Death occurred at <u>11:20 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>M. Carter MD</u>	22b. ADDRESS <u>Neosho Mo</u>	22c. DATE SIGNED <u>10-9-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-10-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Seneca Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Seneca Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Biddlecome Funeral Home, Seneca, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>10-9-61</u>	REGISTRAR'S SIGNATURE <u>Melvin C. Bowman</u> <u>by N. Belka</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

OCT 17 1961

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 W. E. Edlerome

Licensed Embalmer No. 2174

P. O. Address Seneca 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.