

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032657

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8005** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 22 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE <i>Mo.</i>	b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MISSOURI</i>		c. CITY OR TOWN <i>ST. Louis</i>	
Length of stay in lb		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY # 1 HOSP.</i>		d. STREET ADDRESS (If outside, give location) <i>6449 Colletta Dr.</i>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <i>HENRY</i> Middle Last <i>LINK</i>			Month <i>AUGUST</i> Day <i>14</i> Year <i>1962</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB 29 1880</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED MAINTENANCE MAN</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <i>82</i>
11. BIRTHPLACE (City and state or country) <i>GERMANY</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>LOUIS LINK</i>		13b. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	14. NAME OF HUSBAND OR WIFE <i>MARY LINK</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No Ne</i>	17. INFORMANT Address <i>OLIVER LINK 6449 Colletta Dr.</i>
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) <i>Thrombosis Rt. Renal Artery</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Post-operative Bronchopneumonia</i>			
DUE TO (c) <i>Adenocarcinoma Rectum, resected</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>154X</i>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
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 <i>7-17-62</i> to <i>8-14-62</i> and last saw her/him alive on <i>8-14-62</i> Death occurred at <i>4:30</i> <i>P.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Thomas A. Schneider, MD</i>		22b. ADDRESS <i>1515 LAFAYETTE</i>	22c. DATE SIGNED <i>8-14-62</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>AUG 17, 1962</i>	23c. NAME OF CEMETERY OR CREMATORY <i>LAUREL HILL GARDENS</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Co., MO</i>
24. FUNERAL DIRECTOR ADDRESS <i>Thomas Kulis 2906 Greaves</i>	25. DATE RECD. BY LOCAL REG. <i>AUG 17 1962</i>	26. REGISTRAR'S SIGNATURE <i>Roald Smith, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SCHEIDER  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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, Elena Province

Licensed Embalmer No. 3402

P. O. Address 2906 Gravois

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.