

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011624

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1630 STATE FILE NUMBER

FILED APR 1 1963

DO NOT WRITE ON THIS STUB	AMENDED	DATE AMENDED	DOCUMENT
VS 300 Rev. 4/59			
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4 0			
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9 157X			
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12 68-0			
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1. PLACE OF DEATH
 a. COUNTY JACKSON
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Length of stay in 1b 50 years
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION TRINITY LUTHERAN HOSPITAL Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE MISSOURI b. COUNTY JACKSON
 c. CITY OR TOWN KANSAS CITY Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 3222 E LINWOOD Reside on Farm Yes No

3. NAME OF DECEASED First OTTO Middle B Last FLINK
 4. DATE OF DEATH Month March Day 10 Year 1963

5. SEX MALE 6. COLOR OR RACE CAUC 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH OCT 6 1892 9. AGE (last birthday) 70
 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST
 10b. KIND OF BUSINESS OR INDUSTRY MILLING BUSINESS 11. BIRTHPLACE (City and state or country) ROGLE SWEDEN
 12. CITIZEN OF WHAT COUNTRY U.S.A

13a. FATHER'S NAME CARL SWANSON FLINK 13b. MOTHER'S MAIDEN NAME ANNA MARIA LINDALL 14. NAME OF HUSBAND OR WIFE HELENA FLINK

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. [redacted] 17. INFORMANT Address FRANK FLINK 6907 METCALF PARK, KANS OVERLAND

18. CAUSE OF DEATH (Enter only one cause per line)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Gastric Hemorrhage
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ulcerating carcinoma pancreas
 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.
 Yes No Unknown.

19. WAS AUTOPSY PERFORMED? YES NO
 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 3-9-63 to 3-10-63 and last saw him live on 3-9-63
 Death occurred at 7:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature] 22b. ADDRESS 6400 Prospect KC 32 MO 22c. DATE SIGNED 3-12-63

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE MAR 13, 1963 23c. NAME OF CEMETERY OR CREMATORY MT MORIAH CEMETERY 23d. LOCATION (City, town, or county) (State) KANSAS CITY MO

24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS ADDRESS 1331 BRYNMAH CREEK KANSAS CITY MO. 25. DATE REC'D. BY LOCAL REG. 3-13-63 26. REGISTRAR'S SIGNATURE [Signature]

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF H. Hartwig MEDICAL CERTIFICATION

Dr. Richard H. Manning
Date - 3-28-64
200-5:00 PM
0-82

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 Chester K. Brown

Licensed Embalmer No. 4931

P. O. Address KE 110

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.