

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Madaway  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Maryville (NO. St Francis Hosp. St.: \_\_\_\_\_ Ward)

Registration District No. 625 File No. 16783  
Primary Registration District No. 3031 Registered No. 28

FULL NAME James H Lynch

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)  
DATE OF BIRTH Jan 27, 1877 (Month) (Day) (Year)  
AGE 38 yrs. 3 mos. 26 ds. if LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

DATE OF DEATH May 23, 1915 (Month) (Day) (Year)

OCCUPATION (a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

I HEREBY CERTIFY, that I attended deceased from May 15, 1915, to May 24, 1915, that I last saw him alive on May 24, 1915, and that death occurred, on the date stated above, at 1 P. m.  
The CAUSE OF DEATH\* was as follows:

BIRTHPLACE (City or town, State or foreign country) Missouri

severe septicaemia following an infected hand.  
194B  
36 (Duration) yrs. mos. ds.

PARENTS  
NAME OF FATHER John V Lynch  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky  
MAIDEN NAME OF MOTHER Mary J Fawbush  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

Contributory (SECONDARY) \_\_\_\_\_ (Duration) yrs. mos. ds.  
Signed) H. M. Hull M. D.  
5-24-1915 (Address) Maryville Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) John V Lynch  
(ADDRESS) Maryville Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_ yrs. \_\_\_\_ mos. & \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Where was disease contracted if not at place of death? Maryville Mo.  
Former or usual residence Maryville Mo.

Filed MAY 21 1915 J. R. Anthony REGISTRAR

PLACE OF BURIAL OR REMOVAL Oak Hill East DATE OF BURIAL May 24, 1915  
UNDERTAKER Price McCreel ADDRESS Maryville

N. B.—Every item of information on this certificate is important. Every item of information on this certificate is important. Every item of information on this certificate is important.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

PLACE OF DEATH  
*Kodaway*  
County  
Township  
or  
Village  
or  
City (NO. *625* St. *3031* Ward) *58*

2 FULL NAME *James L. Lynch*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>M</i>	4 COLOR OR RACE <i>W.</i>	5 SINGLE MARRIED WIDOWED OR DIVORCED <i>M.</i> (Write the word)
6 DATE OF BIRTH <i>Satisfactory Information Supplied.</i>		
7 AGE <i>Satisfactory Information Supplied.</i>		If LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country)		
PARENTS	10 NAME OF FATHER	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country)	
	12 MAIDEN NAME OF MOTHER	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
*May 25 1915*  
(Month) (Day) (Year)

17 *Satisfactory Information Supplied.*  
I CERTIFY, that I attended deceased from *1880* to *1915*, that I have seen *1880* alive on *1915*, and that death occurred, on the date stated above, at *1880* m.

The CAUSE OF DEATH\* was as follows:  
*Septicemia following and infected hand. Accidental from scratch by cherry tree*

CONTRIBUTORY (Secondary) *1880*  
(Duration) *1880* yrs. *1880* mos. *1880* ds.

(Signed) *H. M. Hadley Jr.* M.P.  
*5-24 1915* (Address) *Maryville Mo.*

\*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
*Satisfactory Information Supplied.*

At place of death: yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted if not at place of death?  
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
*Satisfactory Information Supplied.*

20 UNDERTAKER ADDRESS

SUPPLEMENTARY

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *J. B. Antisney*  
(Address) *Maryville Mo.*

15 Filed *9 1915* 1915 *J. B. Antisney* Registrar

Original file, date *MAY - 1915*, 19.....

All information called for must be written on this Supplementary Certificate.

If death occurred in a hospital or institution, give its NAME instead of street and number.

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