

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

Do not use this space.

15222  
2091

**1. PLACE OF DEATH**

County.....Jackson..... Registration District No.....  
Township.....Kaw..... Primary Registration District No.....  
City.....Kansas City..... (No. 5732)..... Tracy..... St. .... Ward.....

File No. ....  
Registered No. ....

**2. FULL NAME** John D Lynch

(a) Residence. No. 5732 Tracy X5 St., 15 Ward.  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Mrs. Maggie Lynch

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 21 1864

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ____ hrs. or ____ min.
	<u>62</u>	<u>11</u>	<u>—</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... Missouri  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER William Lynch

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... Ireland  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Powers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... Ireland  
(STATE OR COUNTRY)

14. INFORMANT Mrs. Maggie Lynch  
(Address) 5732 Tracy

15. FILE NO. 5/21.1927 McMurray

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 1927

17. I HEREBY CERTIFY That I attended deceased from Sph. 1, 1926 to May 21, 1927.  
that I last saw deceased alive on May 20 1927, and that death occurred, on the date stated above, at 12 15 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cocaine of Acrophages  
44a  
(duration) yrs. 8 mos. da.  
CONTRIBUTORY Cocaine  
(SECONDARY)  
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH..... yes DATE OF Jan 24/27  
WAS THERE AN AUTOPSY..... no

WHAT TEST CONFIRMED DIAGNOSIS Microscopic  
(Signed) W.W.B. Pichey M. D.  
5/21.1927 (Address) 508 Chelmsford, Phila

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Independence, Mo</u>	DATE OF BURIAL <u>5/23/27 19</u>
20. UNDERTAKER <u>QUIRK &amp; TOBIN--20 West Linwood</u>	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

