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

Do not use this space.

29600

1. PLACE OF DEATH

County Buchanan — Registration District No. 85 — File No.

Township — Primary Registration District No. 1001 — Registered No. 1057

City St. Joseph, (No. St. Joseph, s Hospital St. Ward)

2. FULL NAME Margaret Lynch

(a) Residence. No. 2634 South 22nd Street St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June. 4. 1877.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
	50	4	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Household

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

PARENTS

10. NAME OF FATHER John W. Cunningham

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Agency, (STATE OR COUNTRY) Missouri.

12. MAIDEN NAME OF MOTHER Johanna Payne

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Buchanan County, (STATE OR COUNTRY) Missouri.

14. INFORMANT Marshall A Lynch (Address) 2634 South 22nd Street.

15. FILED Oct 17 1927 John G. Utz REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October. 15 1927.

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Oct 13, 1927 that I last saw her alive on Oct 15, 1927, and that death occurred, on the date stated above, at 11/30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary abscess (Traumatic)

115 B

194 B (duration) yrs. mos. 14 ds.

CONTRIBUTORY (SECONDARY) Infection in mouth following extraction of teeth (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) John E. Moore, M.D.

Oct. 15, 1927 (Address) St. Joseph Mo

*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 Easton Mo — DATE OF BURIAL October 17 1927

20. UNDERTAKER H. O. Sidenfaden — ADDRESS 1802 Union Str.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Buchanan — Registration District No. 85 — File No.
Township — Primary Registration District No. 1001 — Registered No. 1057
City St. Joseph (No. ..... St. ..... Ward)

2. FULL NAME Margaret Lynch
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): m

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

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

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED Jan 4, 1927 John G. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 15 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary abscess (Traumatic)
Caused from Extraction of teeth.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Infection following extraction of teeth (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ..... M. D
, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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

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