

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

Do not use this space.

35552

1. PLACE OF DEATH

County.....
Township.....
City..... (No.)

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **10744**.....
St. Ward)

2. FULL NAME

(a) Residence. No. **2009 Wash** St. **N** Ward.
(Usual place of abode)

Length of residence in city or town where death occurred **1** yrs. **2** mos. **0** ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan. 9 1871**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ___ hrs. or ___ min.
56 | **10** | **16**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Nil**
(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)

10. NAME OF FATHER **Gilbert Lynch**

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

12. MAIDEN NAME OF MOTHER **Catherine**

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

14. INFORMANT (Address) **Mrs. F. Woodard City Hospital #2**

15. FILED **30 1927** **Max E. Starceoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov. 25 1927**

17. I HEREBY CERTIFY That I attended deceased from **11/20**, 19**27**, to **11/25**, 19**27** that I last saw him alive on **11/25**, 19**27**, and that death occurred, on the date stated above, at **4:10 a. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
933

indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **9015** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **not known**

IF NOT AT PLACE OF DEATH: **no** DATE OF

DID AN OPERATION PRECEDE DEATH: **no** DATE OF

WHAT TEST CONFIRMED DIAGNOSIS **Chinoid**

(Signed) **D. B. Howell** M. D. , 19 (Address) **City Hosp. #2**

*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 **Greenwood** DATE OF BURIAL **11/30 1927**

20. UNDERTAKER **C. W. Roberts** ADDRESS **303 1/2**

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.

THIS IS A PERMANENT RECORD

