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

Do not use this space.

21913

1. PLACE OF DEATH
County: Laclede — Registration District No. 449 — File No.
Township: Spring Hollow — Primary Registration District No. 5613 — Registered No. 1573
City: Lebanon R#2 (No. ..... St. ..... Ward)

2. FULL NAME: Lillie Lynch
(a) Residence. No. ..... St., ... 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 17 1900

7. AGE: Years 29 | Months 4 | Days 11 | 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) Laclede Co
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER: Albert Ogen
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Laclede
(STATE OR COUNTRY) Co. Missouri
12. MAIDEN NAME OF MOTHER: Hardy
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Laclede Co Mo

14. INFORMANT: Frank Ware
(Address) Lebanon Mo

15. FILED 7/13 1924 J M Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 28 1924

17. I HEREBY CERTIFY, That I ~~attended~~ treated deceased from at various times from 19 the last 2 or 3 years 19 that I last saw her alive on Nov 15 1928, and that death occurred, on the date stated above, at 4 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
63A

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) .....
(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) T. B. Herbert, M. D
6-28, 1924 (Address) Lebanon 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: Dodson Cemetery — DATE OF BURIAL: June 28 1924

20. UNDERTAKER: L B Jones — ADDRESS: Buffalo Mo

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.

1929

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