

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

Do not use this space.

MAR 25 1930

4238

1. PLACE OF DEATH
County Callaway, Registration District No. 104
Township _____ Primary Registration District No. 3008
City Fulton, Mo, (No. _____) St. _____ Ward _____

File No. _____
Registered No. 24

2. FULL NAME Arthur Woodson Lynes,
(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. da. How long in U. S., if of foreign birth? yrs. mos. ds.

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 Husband of Pearl Lynes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct, 30th 1872

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	57	3	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor,
(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) Mo,

10. NAME OF FATHER Woodson Lynes,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo,

12. MAIDEN NAME OF MOTHER Martha' Alexander,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo,

14. INFORMANT Mrs, # Pearl Lynes,
(Address) Fulton, Mo,

5. Feb 4, 1930 R. N. Crews
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 4 1930

17. I HEREBY CERTIFY, That I attended deceased from 252 _____, 1930, at _____, _____, 1930, and that I last saw him alive on Feb. 4, 1930, and that death occurred, on the date stated above, at 5:45 A, _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) _____
(duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) A. B. Ferguson, M. D.
, 19 _____ (Address) Fulton 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 Hillcrest Cemetery DATE OF BURIAL 2/5/30

20. UNDERTAKER Herndon-Taylor Furn-Co, ADDRESS Fulton, Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD STATE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Callaway
Township
City Fulton (No.) St. Ward)

Registration District No. 104
Primary Registration District No. 2008

File No.
Registered No. 24
St. Ward)

Ferguson

2. FULL NAME

Arthur Woodson Lynes

(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M | W | 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)

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4 1930

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:

Paralysis
hemiplegic due to
ruptured artery.

CONTRIBUTORY (SECONDARY) Atherosclerosis. (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.

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

20. UNDERTAKER ADDRESS

15. Apr 30 1930 R. N. Crews
REGISTRAR

SUPPLEMENTARY

750

N. B. - If 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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