

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

Do not use this space.

6975

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** No. **5600** **Arsenal**

File No.....
 Registered No. **1840**
 St. **24th** Ward)

2. FULL NAME

Mary Lynch
 (a) Residence. No. **1321 So. Third** St., **22** Ward. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred **3** 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 Colored	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dave Lynch				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 22, 1894				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	35	1	10	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Housewife (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)
Miss.

PARENTS	10. NAME OF FATHER Ratie King
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
	12. MAIDEN NAME OF MOTHER Betty Robertson
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT (Address)
Joe Rappler
ISOLATION HOSPITAL

15. FILED 19 **1930** REGISTRAR
Chas. C. Starck

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 2, 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Jan. 29, 1930**, to **Feb. 2, 1930**, that I last saw her alive on **Feb. 2, 1930** and that death occurred, on the date stated above, at **5:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
237 (duration) yrs. **2** mos. ds.

CONTRIBUTORY (SECONDARY) **31** (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 **X-ray & Sputum**
 (Signed) **Thomas J. Johnson**, M. D.

2-g, 1930 (Address) **ISOLATION HOSPITAL**

*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
Father Klicke's DATE OF BURIAL **Feb. 21, 1930**

20. UNDERTAKER
J. Behol ADDRESS **2702**

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.

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Dr. Miller

