

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

Do not use this space.

39652

1. PLACE OF DEATH

County Jackson Registration District No. 300
Township Kaw Primary Registration District No. 1000
City Kansas City (No. 3910 Garfield) St. _____ Ward _____

File No. _____
Registered No. 1220

2. FULL NAME Henry A. Lynn

(a) Residence. No. 3910 Garfield St. 13 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 **Male**
4. COLOR OR RACE **White**
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 31, 1845**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
85 8 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Farmer**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer **Retired 16 years**

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) **Missouri**

10. NAME OF FATHER **Don't know**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) **Don't know**

12. MAIDEN NAME OF MOTHER **Don't know**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) **Don't know**

14. INFORMANT Wm M Lynn
(Address) 3910 Garfield

15. FILED 1/29 1930 M. M. Crowe REGISTRAR
Asst

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12, 27 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and 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:

Chronic myeloid leukaemia
935
77
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Chronic myeloid leukaemia
(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? Yes

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Stanley M. Hall M.D.

1727, 1930 (Address) Highly Crown

*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 Forest Hill DATE OF BURIAL Dec 29 30

20. UNDERTAKER R. V. Lindsey & Son ADDRESS City

WRITE PLEASE, WITH UNFADING INK... THIS IS A PERMANENT RECORD

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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