

WRITE PLAINLY, 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.

NOV 28 1934

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

Do not use this space.

36775

1. PLACE OF DEATH

72 County *New Madrid* Registration District No. *604*  
7 Township *New Madrid* Primary Registration District No. *435-8*  
2 City *New Madrid* (No. ....) St. .... Ward)

2. FULL NAME

*Willie 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 *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *L*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 8 - 1933*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
*1* *15*

OCCUPATION 8. Trade, profession, or particular kind of work done, as planner, sawyer, bookkeeper, etc. *L*  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *L*  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) *New Madrid* (STATE OR COUNTRY) *mo*

13. NAME *William Lynch*

14. BIRTHPLACE (CITY OR TOWN) *unk* (STATE OR COUNTRY)

15. MAIDEN NAME *Bessie Crow*

16. BIRTHPLACE (CITY OR TOWN) *Ill* (STATE OR COUNTRY)

17. INFORMANT *William Lynch* (ADDRESS) *New Madrid, mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *East Side* DATE *Oct 24 1934*

19. UNDERTAKER *Richards Undert Co.* (ADDRESS) *New Madrid mo*

20. FILED *11/19/34* 1934 *Wozzmann* U.S. Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 23*, 19*34*

22. I HEREBY CERTIFY, That I attended deceased from *10/23*, 19*34*, to *10/23*, 19*34*

I last saw ~~her~~ alive on *10/23/34*, 19... Death is said to have occurred on the date stated above, at *3 P* m.

The principal cause of death and related causes of importance were as follows:

*Colitis*  
*1195*  
Date of onset

Other contributory causes of importance:  
*Whooping Cough*

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ....., 19...

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....  
(Signed) *McNeil* *100*  
(Address) *New Madrid Mo* *M.D.*

