

FILED APR 8 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12498

State File No.

Registration District No. 784

Primary Registration District No. 2

Registrar's No. 629

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Admitted 2/1/40
(Specify whether
In this community years, months or days) 530

3. (a) PRINT FULL NAME William A. Lynch

3. (b) If veteran, name war World War 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edith 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased July 5, 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 8 25 hr. - min.

9. Birthplace Ullin, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business WPA

MOTHER FATHER { 12. Name John Lynch
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

{ 14. Maiden name Mary Octavia Stokes
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Clinical Clerk
(b) Address VAF, Jefferson Barracks, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-31-40
(Month) (Day) (Year)

(c) Place: burial or cremation Ullin, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) MAR 30 1940 4700 Washington Ave.

19. (a) (Date received local registrar) (b) DR. Meyer (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
(c) City or town Ullin
(If outside city or town limits, write "RURAL")
(d) Street No. -
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? - years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30
year 1940 hour 12:40 minute _____ A. M.

21. I hereby certify that I attended the deceased from February 1,
1940 to March 30, 19 40
that I last saw him im alive on March 30, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death
Pneumonia, bronchial, confluent,
right middle and lower lobes,

Due to untyped.

Duration

5 days.

Due to 107W

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations No Operation.

Of autopsy No autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

7 AM While at work? Ch. Med. Off., VAF, Jeff Bks., Mo.
(Specify type of place) (Means of injury)
23. Signature C. W. Hughes, M.D. (M. D. or other)
Address Ch. Med. Off., VAF, Jeff Bks., Mo. Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 4 1945

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

....., Registered Apprentice No.....

working under my personal supervision.

Signed

J. B. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.