

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.

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4375

1. PLACE OF DEATH:
 (a) County St Louis
 (b) City or town _____
 (c) Name of hospital or institution:
3060 Cass
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community about 17 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME THOMAS LYNCH
 3. (b) If veteran, name war _____
 3. (c) Social Security No. 493-60-7886

4. Sex Male 5. Color or race Cal
 6. (a) Single, widowed, married, divorced. Married
 6. (b) Name of husband or wife. Clara 6. (c) Age of husband or wife if alive 39 years
 7. Birth date of deceased 4 (Month) 14 (Day) 1897 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>3</u>	<u>1</u>	_____ hr. _____ min.

9. Birthplace Cold Water (City, town, or county) Miss. (State or foreign country)

10. Usual occupation Labor

11. Industry or business Public Service

12. Name Alford Lynch

13. Birthplace Texas (City, town, or county) Miss. (State or foreign country)

14. Maiden name Lynch not known

15. Birthplace not known (City, town, or county) Miss. (State or foreign country)

16. (a) Informant's own signature Clara Lynch
 (b) Address 3060 Cass Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-40 (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director W. H. Anderson
 (b) Address 2625 Glasgow

19. (a) MAY 16 1940 (Date received local registrar) (b) J. B. Beck (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County _____
 (c) City or town St Louis (If outside city or town limits, write "RURAL") 21
 (d) Street No. 3060 Cass Ave (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 15 year 1940 hour 3:30 minute _____ A. M.
 21. I hereby certify that I attended the deceased from 4-26, 1940 to 5-15, 1940 that I last saw him alive on 5-13, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease
chronic myocarditis
 Due to (6 mo duration)

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

Major findings: _____
 Of operations _____
 Of autopsy _____

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____
 23. Signature Robert M. Scott (M. D. or other) _____
 Address 2839th Dickson Date signed 5-16-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 A. D. Richardson
Licensed Embalmer No. 2928
P. O. Address 2625 Glasgow

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.