

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37888**
4486
Registrar's No.

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2217 Agnes
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 days (Specify whether years, months or days)
In this community 45 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2217 Agnes
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME MARTHA ANN LYNCH

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife John Lynch 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 19, 1859
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Platte Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Simpson

{ 13. Birthplace Cumberland, Virginia
(City, town, or county) (State or foreign country)

{ 14. Maiden name Eucetta Baldwin

{ 15. Birthplace Platte Co., Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant John L. Lynch

(b) Address 2721 Olive

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/40
(Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Quirk & Fabin Co.

(b) Address R. C. Co.

19. (a) 11-25-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Nov. 9
1940 19 _____ to Nov 24 19 40

that I last saw him alive on Nov. 24
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis

Due to Chronic Nephritis

Due to 131

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

Major findings: Of operations None

Of autopsy None

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) None

(b) Date of occurrence None

(c) Where did injury occur? None
(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) Manner of injury None

23. Signature Walter Bledsoe (M. D. or other) MD

Address Walter Bledsoe Date signed 11/25/40

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

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

Maurice Quint

Licensed Embalmer No.

3634

P. O. Address

20 W. Lincoln

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

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