

No. 2  
1-4-41  
5-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

28777

State File No. ....

FILED SEP 10 1941  
303

Primary Registration District No. 5669

Registrar's No. ....

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

1. PLACE OF DEATH:  
(a) County Linn  
(b) City or town Meadville Parson Creek Twp Rural  
(c) Name of hospital or institution: X  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X  
In this community 30 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Linn  
(c) City or town Meadville Rural Parson Creek Twp  
(d) Street No. R.F.D. # 2  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Giles Leonard Lynd  
(b) If veteran, name war: \_\_\_\_\_ (c) Social Security No. X

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month AUG. day 9  
year 1941 hour 3 minute 30 P. M.  
21. I hereby certify that I attended the deceased from JULY  
14 1941 to AUG. 9 1941  
that I last saw him alive on AUG. 9 1941  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife: X 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased December 25 1860  
(Month) (Day) (Year)

Immediate cause of death: PROSTATIC CARCINOMA  
PULMONARY EDEMA  
SENILITY  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
80 8 15 hr. min.  
9. Birthplace Orleans Co New York  
(City, town, or county) (State or foreign country)  
10. Usual occupation Gardner

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business: \_\_\_\_\_  
MOTHER FATHER { 12. Name Jacob Lynd  
13. Birthplace New York  
14. Maiden name Delilah Cropsey  
15. Birthplace New York  
16. (a) Informant Emma Warren  
(b) Address Meadville Mo. R.F.D. # 2  
17. (a) Burial (b) Date thereof Aug 11 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Meadville cemetery  
18. (a) Signature of funeral director Smiley Funeral Home  
(b) Address Wheeling Mo  
19. (a) Aug 11-41 (b) E. J. Warren  
(Date received local registrar) (Registrar's signature)

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 S. H. Hansen (M. D. or other) 2-00  
Address Meadville Mo. Date signed 8-11-41

432 (Licensed Embalmer's Statement on Reverse Side)

**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.....

*Frank L. Smiley*

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

working under my personal supervision.

Signed.....

*Frank L. Smiley*

Licensed Embalmer No. *470*

P. O. Address *Whiting Mo*

**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, fact should be so stated above.**