

S. No. 2  
4-1.4-41  
7. 5-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED NOV 17 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34256

Registration District No. 366

Primary Registration District No. 5091

Registrar's No.

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

1. PLACE OF DEATH:

(a) County BATES-

(b) City or town BUTLER - RFD 2 - SPRUCE  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 60 YRS-  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO- (b) County BATES?

(c) City or town RFD BUTLER MO-5  
(If outside city or town limits, write "RURAL")

(d) Street No. Spruce twp 0  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME THOMAS H. LYNCH

3. (b) If veteran, name war X

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT- day 18<sup>TH</sup>  
year 1941 hour 10: minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct 10 1941 to Oct. 18 1941  
and that I last saw him alive on Oct 14 1941  
and that death occurred on the date and hour stated above.

4. Sex MA 5. Color or race W

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife IDA-CARVER-

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug-10-1860  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_

Cerebral hemorrhage

Due to \_\_\_\_\_

Due to Ch. Hypertension  
arteriosclerosis

Other conditions generalized  
(Include pregnancy within 3 months of death)

8. AGE: Years 81 Months 2 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 830

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER { 12. Name LYNCH

13. Birthplace Illinois / \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name MEGEE

15. Birthplace UNION MO - 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mina Herman

(b) Address Rt - 2 - Butler Mo.

17. (a) BURIAL (b) Date thereof OCT-20-41  
(burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BETHEL CEM-

18. (a) Signature of funeral director BOOTH FUNERAL HOME

(b) Address BUTLER MO-

19. (a) Oct 20 1941 (b) Laura H. Odneal  
(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? 0

(Specify type of place) \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

23. Signature Cates W. Luley (M. D. or other) M.D.  
Address Butler, Mo Date signed 10/20/41

RECEIVED

District Health Officer No. 7,

District File Number

11-4-1885-

Date Filed

11-13-41

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**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

*John G. Hudewood*

Licensed Embalmer No.

3585

P. O. Address

Butler 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.**