

S. No. 2  
M-9-4-41  
v. 5-17-39  
I X29484

23488

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2965

FILED AUG 17 1942

Registration District No. 149

Primary Registration District No. 1002

48  
38  
8  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County: Jackson  
(b) City or town: Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Little Sisters of the Poor.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: 1 yr. 9 mos.  
(Specify whether years, months or days) 34 Years

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Missouri (b) County: Jackson  
(c) City or town: Kansas City Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No.: 5331 Highland Ane.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country: 0

3. (a) PRINT FULL NAME: Maggie LYNCH.  
3. (b) If veteran, name war: None  
3. (c) Social Security No.: None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month: August day: 5th, year: 1942 hour: 8 minute: A.M.  
21. I hereby certify that I attended the deceased from June 15, 1942 to Aug 5, 1942.  
that I last saw her alive on Aug 4, 1942 and that death occurred on the date and hour stated above.

4. Sex: Female / 5. Color or race: White  
6. (a) Single, widowed, married, divorced: Widowed  
6. (b) Name of husband or wife: John C. Lynch  
6. (c) Age of husband or wife if alive: 30th years  
7. Birth date of deceased: March 30th, 1866 (Month) (Day) (Year)

Immediate cause of death: Cerebral thrombosis  
Due to: Generalized arteriosclerosis  
Due to: 83 B  
Other conditions: (Include pregnancy within 3 months of death)  
Duration: 3 days

8. AGE: Years: 76 Months: 4 Days: 5 If less than one day: hr. min.  
9. Birthplace: Liberty Mo. (City, town, or county) (State or foreign country)  
10. Usual occupation: Dress Maker, (Retired)

PHYSICIAN  
Major findings: Of operations: none  
Of autopsy: none  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
12. Name: Unknown  
13. Birthplace: Unknown (City, town, or county) (State or foreign country)  
14. Maiden name: Unknown  
15. Birthplace: Unknown (City, town, or county) (State or foreign country)  
16. (a) Informant: Mrs Grace Warneke  
(b) Address: 2504 East 28th Street  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/7/42 (Month) (Day) (Year)  
(c) Place: burial or cremation: St. Marys Indep. Mo.  
18. (a) Signature of funeral director: Mellody-McGilley.  
(b) Address: K. C. Mo.  
19. (a) 8-6-42 (Date received local registrar) (b) M. M. Boone (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: 0  
23. Signature: John T. Shermser (M. D. or other) M.D.  
Address: 140 2nd Street Bldg. Date signed: 8-6-42

361

(Licensed Embalmer's Statement on Reverse Side)

9/2/42

*Ref T. L. ...*

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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.....

*[Handwritten Signature]*  
.....  
Licensed Embalmer No.....  
P. O. Address..... *KC*

**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.**