

FILED MAY 15 1943

Registration District No. \_\_\_\_\_

Primary Registration District No. 6076

Registrar's No. 1104

1. PLACE OF DEATH: St. Louis

(a) County \_\_\_\_\_

(b) City or town Koch, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 1760 days  
(Specify whether years, months or days)

In this community 6 yrs.

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 9  
(If outside city or town limits, write "RURAL.")

(d) Street No. Homer Phillips Hospital  
(If rural, give location)

(e) Citizen of foreign country? Unknown - Has been in U.S.A. 14 yrs. (Yes or No) 1

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LIONEL RANDOLPH LYNCH

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

4. Sex male 5. Color or race negro

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased May 30 1912  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

30	11	6	hr. _____ min.
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9. Birthplace Trinidad B.W.I. I  
(City, town, or county) (State or foreign country)

10. Usual occupation Medical Doctor

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

MOTHER FATHER

12. Name Lionel Robert Lynch

13. Birthplace Trinidad B.W.I. I  
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Blackman

15. Birthplace Trinidad B.W.I. I  
(City, town, or county) (State or foreign country)

16. (a) Informant Records

(b) Address Koch Hospital, Koch, Mo.

17. (a) Ship via airplane (b) Date thereof 5/9/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New York City, N.Y.

18. (a) Signature of funeral director Thomas J. ...

(b) Address 2817 ...

19. (a) MAY 11 1943 (b) C. J. ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6  
year 1943 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from 7-6-38  
to 5-6-43, 19\_\_\_\_, to 5-6-43, 19\_\_\_\_

that I last saw him alive on 5-6-43, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pulmonary Tuberculosis

Duration 5 yrs. (?)

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

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

Other conditions Tuberculosis Enteritis;  
(Include pregnancy within 3 months of death)  
Empyema + Pericarditis - it.

Major findings: 1361

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

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) \_\_\_\_\_

(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)

23. Signature Thomas J. ... Means of injury ...  
(M. D. or other)

Address Koch Hosp. Date signed \_\_\_\_\_

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

96  
0  
0

**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.....  
..... *myself* ....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. *2266*

P. O. Address *2872 Thomas & Louis, 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.**