

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

FILED JUN 2 1943

Registration District No. **218**

Primary Registration District No. **3017**

1. PLACE OF DEATH:

(a) County **Cooper**
(b) City or town **Boonville Mo.**
(c) Name of hospital or institution: **Ravenswaay Clinic.**
(d) Length of stay: In hospital or institution **About 9hrs**
In this community **46 yrs 1 mo. 2 da.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cooper**
(c) City or town **Boonville Mo**
(e) Citizen of foreign country? **(Yes or No)**
If yes, name country **()**

3. (a) PRINT FULL NAME **Gabriel Lynch**

3. (b) If veteran, name war **World War** 3. (c) Social Security No. **I**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Genevieve Lynch** 6. (c) Age of husband or wife if alive **27** years

7. Birth date of deceased **April 10 1897**
(Month) (Day) (Year)

8. AGE: Years **46** Months **I** Days **2** If less than one day **hr. min.**

9. Birthplace **Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Feed Store Operator**

11. Industry or business

MOTHER FATHER { 12. Name **John W Lynch.**
13. Birthplace **Dont Know**
14. Maiden name **Sarrie Hargis.**
15. Birthplace **Dont Know.**

16. (a) Informant **Mrs Genevieve Lynch**
(b) Address **Higbee Mo**

17. (a) **Burial** (b) Date thereof **May 14 1943**
(c) Place: burial or cremation **Moberly Mo**

18. (a) Signature of funeral director **Joe W Burton**
(b) Address **Higbee Mo**

19. (a) (b) (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **11**
year **1943** hour **11:50** minute **P. M.**

21. I hereby certify that I attended the deceased from **5-11-**
1943 to **5-11-** **1943**;
that I last saw **her** alive on **5-11-** **1943**;
and that death occurred on the date and hour stated above.

Immediate cause of death **PERFORATED ~~STOMACH~~ PARTIS
ULCER (?) 15HRS.**

Due to
Due to
Other conditions (include pregnancy within 3 months of death) **117a2**

Major findings: Of operations **NONE**
Of autopsy **N.R.T. DONE**

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature **Robert H. Wells** (M. D. or other)
Address **Boonville, Mo.** Date signed **5-12-43**

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

RECEIVED

District Health Officer No. 8,

File Number

6-1-43

MAR 17 1943

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 66

Registration District No. 218

Primary Registration District No. 2017

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

1. PLACE OF DEATH

(a) County Cooper
(b) City or town Donnell
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Riversway Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME

Gabriel Lynch

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased April 10 1925
(Month) (Day) (Year)

8. AGE: Years 46 Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) May 17 43 (b) Dr. Chas. Swape
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 11
year 1925 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I saw _____ alive or _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

Duration _____
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place)
While at work? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

1125

S-17699

ONE OF TWO

1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960