

No. 2
1-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42-185

State File No. _____

JAN 5 1944 149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 5418

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 hrs. 15 mins.
(Specify whether years, months or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 517 So. Lawndale
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Belle Lynch

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 17
year 1943 hour 2 minute _____ P. M.

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife Geo W Lynch

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Mar 2 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 16 1943 to December 17 1943
that I last saw her alive on December 17 1943
and that death occurred on the date and hour stated above.

8. AGE: Years 78 Months 9 Days 15
If less than one day hr. _____ min. _____

Immediate cause of death Cerebral Thrombosis Duration _____

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

Due to 83 1/2

Due to _____

10. Usual occupation Homemaker

11. Industry or business Henry Brincker

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

12. Name Walter

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

Major findings: Of operations _____

Of autopsy See above

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

14. Maiden name Unknown 9
(City, town, or county) (State or foreign country)

15. Birthplace _____

16. (a) Informant Jessie Ruth

(b) Address 428 S. Huntington

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial, cremation, or removal Burial

(b) Date thereof 12-20-43
(Month) (Day) (Year)

(c) Place: burial or cremation Mount Washburn

(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? _____

18. (a) Signature of funeral director T. C. Brown

(b) Address No

19. 12-20-43 (Date received local registrar)

(b) T. C. Brown (Registrar's signature)

While at work? _____ (Specify type of place)

(a) Means of injury _____

23. Signature Dr. R. Johnson (M. D. or other)

Address Med. Dir. Gen'l Hosp. Date signed 12-18-43

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

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 *W. H. Blackman*.....

Licensed Embalmer No. 2244.....

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.