

FILED FEB 1 1944  
Registration District No. **818**

Primary Registration District No. **1003**

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

**1. PLACE OF DEATH:**  
(a) County.....  
(b) City or town **St Louis Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**De Paul Hospital**  
(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)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **MO** (b) County.....  
(c) City or town **St Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **4135 Lea Pl.**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

**3. (a) PRINT FULL NAME** **Fannie Lynch**  
(b) If veteran, name war.....  
(c) Social Security No.....

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **Jan** day **22nd**  
year **1944** hour **10.30** minute **P.M.M.**

**5. Color or race** **FEMALE** **W**  
**6. (a) Single, widowed, married, divorced** **married**  
**6. (b) Name of husband or wife** **John J. Lynch**  
**6. (c) Age of husband or wife if alive** **62yrs** years  
**7. Birth date of deceased** **March 26th 1881**  
(Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from**  
**Jan 1**, 19**44** to **Jan 22**, 19**44**  
that I last saw him alive on.....  
and that death occurred on the date and hour stated above.

**8. AGE:** Years **62** Months **9** Days **26**  
If less than one day  
hr. min.

Immediate cause of death  
**Diabetic Gangrene**  
Due to.....  
**Diabetes Mellitus (1-Month)**  
Other conditions  
(Include pregnancy within 3 months of death)

**9. Birthplace** **St Louis Mo**  
(City, town, or county) (State or foreign country)  
**10. Usual occupation** **Housewife**

Major findings:  
Of operations.....  
Of autopsy.....  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

**11. Industry or business**  
**12. Name** **John Chalcraft**  
**13. Birthplace** **England**  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **Anna Wallace**  
**15. Birthplace** **Ireland**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **John Lynch Jr.**  
(b) Address **4135 Lea Pl.**  
**17. (a) Burial** (b) Date thereof **1-26-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary Cemetery.**  
**18. (a) Signature of funeral director** **Sullivan Bros.**  
(b) Address **2849 N. Euclid Ave**

**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?

**19. (a)** **JAN 27 1944** (Date received local registrar)  
**J. F. Bredeck** (Registrar's signature)

While at work? (Specify type of place) Means of injury?  
**23. Signature** **J. F. Bredeck** (M. D. or other)  
Address **4114 W. Florissant** Date signed **1/27/44**

847

Dr. Medler

4114 W. Florrisant 12-2 5-7

Co. 2783. office

---

---

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.....

*Albert Mayfield*  
.....  
Licensed Embalmer No. *3077*

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.**