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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 25 1944

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17091

Primary Registration District No. 1002

Registrar's No. 2185

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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: 4
3240 Norledge, Nora Rae Restorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 10 Weeks (Specify whether years, months or days)
In this community: 25 years

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 S. Lawndale
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: GEORGE WASHINGTON LYNCH

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widower

6. (b) Name of husband or wife: Mary B.

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

7. Birth date of deceased: Nov. 28, 1861 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
82	5	21 ~~11~~	hr. min.

9. Birthplace: (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation: Retired Laborer

11. Industry or business: C. M. & St. P. Railroad

FATHER
12. Name: Unknown
13. Birthplace: " (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name: Unknown
15. Birthplace: " (City, town, or county) (State or foreign country) 9

16. (a) Informant: Mrs. C. R. Miller
(b) Address: 428 S. Kensington

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 20, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Washington Cemetery

18. (a) Signature of funeral director: C. H. Blackman & Son, Inc.
(b) Address: Kansas City, Mo.

19. (a) 5-20-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 19 year: 1944 hour: 10 minute: 10 AM.

21. I hereby certify that I attended the deceased from May 16, 1944, to May 18, 1944, that I last saw him alive on May 18, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Sclerosis	1 yr
Due to Arteriosclerosis	3 yr
Due to Hypertension	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 46 N	
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? (Specify type of place)
While at work? (Specify) Means of injury

23. Signature: R. L. H. Clark (M. D. or other)
Address: 5242 Bryce Date signed: 5/19/44

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.