

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21381

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

FILED JUL 1944

Registration District No. 11

Primary Registration District No. 3012

Registrar's No. 93

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay 24
(c) City or town Rural Excelsior Springs, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. Ex (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country U

3. (a) PRINT FULL NAME Sanzie Wilson Lynn
(b) If veteran, name war None (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 27
year 1944 hour 4:00 minute _____ P. M.

4. Sex Male 5. Color or race White 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: April 12 1874
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____ 19____, _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
70 2 15 _____ hr. _____ min.

Immediate cause of death Coronary Occlusion Duration _____
Due to _____
Due to _____

9. Birthplace Excelsior Springs, Missouri
(City, town, or county) (State or foreign country)

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name James Samuel Lynn
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Maggie Moore
15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Coronary Occlusion
(b) Date of occurrence June 27-1944
(c) Where did injury occur? 2 mi west of Spgs Clay Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on farm at home
While at-work? yes (Specify type of place) (e) Means of injury _____

16. (a) Informant Stephan
(b) Address Excelsior Springs, Mo.

17. (a) June 28 Burial (b) Date thereof June 28 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill Cemetery

18. (a) Signature of funeral director Charles Michael
(b) Address Excelsior Springs Mo

19. (a) 6-28-44 (b) Mrs Sade Redman
(Date received local registrar) (Registrar's signature)

23. Signature W. Prother Coroner
(M. D. or other)
Address Excelsior Springs Mo. Date signed 6-28-44

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 8,
District File Number

Filed 7-6-44

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 Carl Rapp
Licensed Embalmer No. 3458
P. O. Address Ex. Spgs, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 93

Registration District No. 71

Primary Registration District No. 3012

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Franklin
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days) (Specify whether)

3. (a) PRINT FULL NAME

Sannie W. Lynn

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.....

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

7. Birth date of deceased April 12 (Month) (Day) (Year)

8. AGE: Years no Months 2 Days no less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Date received local registrar) (b) Mrs Sadie Redman (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 July year 1944 minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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) (c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

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

21381