

FILED JAN 9 1945

State File No. _____

Registration District No. 275

Primary Registration District No. 3053

Registrar's No. 153

1. PLACE OF DEATH:

(a) County Polk

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

(c) Name of hospital or institution: Mr. Farland Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community 4 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Katherine Lynch

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

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

7. Birth date of deceased Oct. 20, 1913
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>31</u>	<u>2</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm. Hartley

13. Birthplace Blair, Kansas
(City, town, or county) (State or foreign country)

14. Maiden name Belle Wilson

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

16. (a) Informant Mrs. Belle Dodson

(b) Address Rolla, Mo.

17. (a) Funeral (b) Date thereof 12/30/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rolla, Mo.

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

(b) Address 508 W. 8th St. Rolla, Mo.

19. (a) 12-30-44 (b) Katherine Lynch
(Date received local registers) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 31
year 1944 hour 6 minute 05 P.M.

21. I hereby certify that I attended the deceased from Dec. 26, 1944 to Dec. 27, 1944

that I last saw her alive on Dec. 27, 1944

and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Duration

Due to Following surgery

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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) (Type of injury)

23. Signature Katherine Lynch or other _____

Address Rolla, Mo. Date signed 12/30/44

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 mw

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3397

P. O. Address Rolla 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 153

Registration District No. 274

Primary Registration District No. 3053

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

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Rolla
(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 _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Katherine Synch

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

4. Sex F 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 Dec 20
(Month) (Day) (Year)

8. AGE: Years 31 Months 2 Days no. If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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) _____ (b) _____
(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 Dec day 27
year 1944 hour _____ minute _____ M.

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

Due to Appendicitis and bilateral salpingitis
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 139d

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) Means of injury _____

23. Signature [Signature] (M. D. or other) 1/2/45

Address Rolla, Mo Date signed _____

SUPPLEMENTARY

S-41870 1944

APR 30 1945