

V. S. No. 2  
100M-5-43  
Rev. 5-17-39  
1 X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **1275**  
Registrar's No. **260**

FILED FEB 6 1945  
Registration District No. **149**

Primary Registration District No. **1002**

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

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:  
**General Hospital No. 2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **12-30-44-1-13-45**  
**28 yr.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **LILLIE LYNCH (WILLIAMS)**  
(b) If veteran, name war **No**  
(c) Social Security No. **NONE**

4. Sex **Female** 5. Color or race **Negro**  
6. (a) Single, widowed, married, divorced **divorced**  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive **9** years  
7. Birth date of deceased **July 13 1892**  
(Month) (Day) (Year)

8. AGE: Years **52** Months **6** Days **0**  
If less than one day hr. min.

9. Birthplace **Waco Texas**  
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

MOTHER FATHER  
11. Industry or business  
12. Name **W<sup>M</sup> WILLIAMS**  
13. Birthplace **TEXAS**  
14. Maiden name **DORA THOMPSON**  
15. Birthplace **TEXAS**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**  
(b) Address **General Hospital No. 2**

17. (a) **BURIAL** (b) Date thereof **1-18-1945**  
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial or cremation **LINCOLN**  
18. (a) Signature of funeral director **FLYNN AND GREEN STREET**  
(b) Address **1819 E. 15 STR.**

19. (a) **1-17-45** (b) **P. E. Brown**  
(Date received local registrar) (Registrar's signature)

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. **3604 Bellaire**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **January** day **13**  
year **1945** hour **11:35** minute **p.** M.  
21. I hereby certify that I attended the deceased from  
**December 30**, 19**44**, to **January 13**, 19**45**  
that I last saw h<sup>e</sup> or alive on **January 13**, 19**45**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Congestive Heart Failure**  
Duration  
Due to **Hypertensive type heart disease**

Due to  
Other conditions (Include pregnancy within 3 months of death) **93 d**

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?

(Specify type of place)  
While at work? (e) Means of injury  
23. Signature **P. E. Brown** (M. D. or other)  
Address **Gen. Hosp #2-600 E. 22** Date signed **1-16-45**

**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.....  
*Wm G. Flynn*

Licensed Embalmer No. 4383

P. O. Address. 1819 E 15<sup>th</sup> St. KCMO

**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.**