V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 1 1945

State File No. 26504

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3477

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: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks (Specify whether
In this community 2 weeks years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 54
(c) City or town Higginsville, Mo 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME DAVID R. 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 Married
6. (b) Name of husband or wife Sarah E. Lynch
6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased Jan. 9 th, 1869 (Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 10 If less than one day hr. min.

9. Birthplace Allville (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Laborer
11. Industry or business General work

FATHER
12. Name Augustus A. Lynch
13. Birthplace Unknown (City, town, or county) (State or foreign country)

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

16. (a) Informant Walter A. Lynch
(b) Address Higginsville Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/20/45 (Month) (Day) (Year)
(c) Place: burial or cremation Higginsville Mo.
18. (a) Signature of funeral director A.H. Hader Funeral Home
(b) Address Higginsville Mo.
19. (a) 8-19-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19th year 1945 hour 7 minute 15P M.

21. I hereby certify that I attended the deceased from June 16, 1945 to Aug 19, 1945 that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Gangrene of left leg due to arteriosclerosis	1 wk
Due to	
Due to	
Other conditions Diabetes Mellitus (Include pregnancy within 3 months of death)	1 yr
Generalized arteriosclerosis	
Major findings: Of operations Gangrene of left foot	
Of autopsy 61	

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 Carl A Brust (M. D. or other)
Address 106 W 14th St K.C. Mo Date signed 8/19/45

(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 Chas E. Wilks.

Licensed Embalmer No. 2644

P. O. Address Kansas City 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.