.S. No. 2
0M—5-43
v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24918

FILED AUG 5 1946

Registration District No. 5175 Primary Registration District No. 6076 Registrar's No. 1580

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

1. PLACE OF DEATH:

(a) County ST LOUIS
(b) City or town NORMANDY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3724 ST ANN LANE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 YRS (Specify whether
In this community 10 YRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS
(c) City or town NORANDY
(If outside city or town limits, write "RURAL")
(d) Street No. 3724 ST ANN LANE
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ELLA A LYNCH
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife JOHN LYNCH
6. (c) Age of husband ~~or wife~~ if alive 62 years
7. Birth date of deceased MARCH (Month) 10 (Day) 1886 (Year)

8. AGE: Years 60 Months 4 Days 17 If less than one day hr. min.

9. Birthplace — (City, town, or county) ILLIONIS (State or foreign country)
10. Usual occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name LAWERNCE McGRAIL
13. Birthplace — (City, town, or county) IRELAND (State or foreign country)

MOTHER
14. Maiden name NORA O MALLEY
15. Birthplace (City, town, or county) IRELAND (State or foreign country)

16. (a) Informant MR JOHN LYNCH
(b) Address 3724 ST ANN LANE
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-30-46 (Month) (Day) (Year)
(c) Place: burial or cremation CALVERY CEM
18. (a) Signature of funeral director MEEK + DICKMAN FUNERAL
(b) Address HOME 4356 WASHINGTON AV
19. (a) 7-30-46 (Date received local registrar) (b) T. G. McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 27th year 1946 hour 10 minute 15 AM M.
21. I hereby certify that I attended the deceased from Feb 1945 to July 27 1946 that I last saw her alive on Feb 26 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure (Acute)
Due to Hyperthyroidism
Due to Myocarditis
Other conditions arteriosclerosis
(Include pregnancy within 3 months of death)

Duration

93 d

Major findings: Of operations Thyroidectomy 1942
R. leg amputated 1942
Of autopsy none

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 [signature] (M.D. ~~or other~~)
Address Carleton Bldg Date signed 7-29

707 (Licensed Embalmer's Statement on Reverse Side)

AUG 9 1946

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.....John Ketter.....

Licensed Embalmer No.....3880.....

P. O. Address.....St Louis 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.