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5-17-39
P1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3410
Registrar's No. 135

FILED JAN 18 1947

Registration District No. 3069 Primary Registration District No. 3069

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

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Richmond Heights
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution St. Marys Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME James P. Lynch
 (b) If veteran, name war _____
 (c) Social Security No. _____

5. Color of hair Black
 Sex male
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Laura
 (c) Age of husband or wife if alive 60 years

7. Birth date of deceased February 1 1880
 (Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 4
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Maintenance man

11. Industry of business St. Louis Public Schools

12. Name Michael J. Lynch

13. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Anna O'Keefe

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

16. (a) Informant Mrs. Laura Lynch

(b) Address 5243 Parklawn Pl.

17. (a) Burial (b) Date thereof 1-8-47
 (Burial, cremation, or removal) (City, town, or county) (Day) (Month) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Chas. J. Strunk

(b) Address 1225 Union Blvd.

19. (a) 1-8-47 (b) Ruth J. Steinhilber
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 080
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5243 Parklawn Pl.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5
 year 1947 hour 4:15 minute _____ P. M.

21. I hereby certify that I attended the deceased from 1945, 19____, to Jan 6, 19____
 that I last saw him alive on Jan 5, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarct
 Due to Cholesterol 2 years
 Due to Arterio Sclerosis
 Other conditions Arterio Hypertrophy
 (Include pregnancy within 3 months of death)
 Major findings: Eupnea, Pulbic
 Of operations Arterio
 Of autopsy NO

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? _____ Means of injury _____

23. Signature W. H. Steinhilber (M. D. or other) _____
 Address Capitol Bldg. Date signed 1-6-47

JUN 3 1947

MAY 23 1953

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.....

J. Allen Davis
Licensed Embalmer No. 4053

P. O. Address.....

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.