

S. No. 2
OM-8-43
v. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11215

State File No. _____

FILED MAR 24 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2624**

100% NEW 901
V08/N 901

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

1. PLACE OF DEATH:

(a) County **St. Louis Missouri**

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

(c) Name of hospital or institution:
4106 Castleman Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **79 Years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **4106 Castleman Ave**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Michael F Lynch**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **11th**
year **1947** hour **7:00** minute **pm**

21. I hereby certify that I attended the deceased from **Mar 10**, 19**47**, to **Mar 11**, 19**47**.
that I last saw h. **e** alive on **Mar 4**, 19**47**,
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**

6. (a) ~~Married~~ **Widowed** 6. (c) Age of husband or wife if alive _____ years

(b) Name of husband or wife **Ceciline**

Immediate cause of death **Chronic Myocarditis**
Pernicious Anemia
Carbosis of Liver

Due to _____

Due to _____

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

7. Birth date of deceased **July** (month) **10th** (Day) **1868** (year)

8. AGE: Years **78** Months **8** Days **1** If less than one day hr. _____ min. **0**

Major findings: Of operations **no**

Of autopsy **no**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10. Usual occupation **Retired Railroad Employee**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **no**

(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? **no**

11. Industry or business **Mo Pac RR**

MOTHER FATHER } 12. Name **Cornealious Lynch**

13. Birthplace **Irelande Fitzsimmons**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary McFitzsimmons**

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

16. (a) Informant **Mrs. Mary Rush**

(b) Address **7124 Lanham Ave**

17. (a) **Burial** (b) Date thereof **3-14-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

While at work? **no** (Specify type of place) Means of injury **no**

23. Signature **J. F. Bredeck** (M. D. or other) **MD**

Address **508 70 Street** Date signed **3/12/47**

18. (a) Signature of funeral director **JOHN A. BARRETT**
2819 Union AVE

(b) Address

19. (a) **MAR 13 1947** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

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..... *W Wilkinson*
..... Licensed Embalmer No..... *3575*

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.