No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUN 14 1947 #68085

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19103

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 5620

1. PLACE OF DEATH:

(a) County

(b) City or town: St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 68 Yrs 5 Mons 21 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: 0

(c) City or town: St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No.: 1312a Wright St. 9
(If rural, give location) 0

(e) Citizen of ~~foreign~~ country? 26 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: ANNA LYNCH

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: ____ years

7. Birth date of deceased: 12 (Month) 15 (Day) 1878 (Year)

8. AGE: Years 68 | Months 5 | Days 21 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: nil

11. Industry or business:

FATHER
12. Name: Matthew Lynch
13. Birthplace: Unknown (City, town, or county) Ireland (State or foreign country)

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

16. (a) Informant: Mrs. Alice Neal
(b) Address: 1312a Wright St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-9-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: Goodhart & Goodhart
(b) Address: 2228 St. Louis Ave

19. (a) JUN 7 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6th year 1947 hour 1:45 minute A M.

21. I hereby certify that I attended the deceased from 2/10/47, 19__, to June 6th, 1947 that I last saw her alive on June 6th, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac decompensation	3 Months
Due to: Hypertensive Cardiovascular Disease	? yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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: 0

23. Signature: J. Lowry Brown (M. D. or other)
Address: 1515 Lafayette Date signed: 6/6/47

Jefferson City Printing Co. (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 Henry M. Brammer

Licensed Embalmer No. 4200

P. O. Address St. Louis

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.