

No. 2
12-45
-17-39
X47070

State File No. _____

FILED AUG 29 1947

Registration District No. _____

Primary Registration District No. 5-787

Registrar's No. 85-

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Charleston (Rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route 2, Box 300
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 10 years (Specify whether
years, months or days)

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

4. Sex Male 2 5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Lucille Lynch 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 14, 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>1</u>	<u>1</u>	hr. _____ min. _____

9. Birthplace (Unknown) S. Carolina
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown 9
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Frank Fair
(b) Address R. 2, Box 355, Charleston, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17, 1947
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director F. J. Sparks
(b) Address Cape Girardeau, Mo.

19. (a) 8-22-47 (Date received local registrar) (b) Mrs. John Bondurant (Registrar's signature) 101

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi 67
(c) City or town Charleston (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. Route 2, Box 300
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15
year 1947 hour 2:00 minute A. M.
21. I hereby certify that I attended the deceased from April 2/7 1947, to Aug 15 1947
that I last saw him alive on Aug. 14 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure Duration _____
Due to W. hypertensive Cardio-Vascular Disease 6 mo
Due to Chronic Interstitial acc. Heart 10-12 mo
Other conditions Dial
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature W. A. Fungal (M. D. or other) _____
Address 204 Locust St Date signed 8/18/47

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

RECEIVED

District Health Office No. 2,

District File No. 847-1126

Date Filed 8-25-47

SEP 8 1947

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 Frank Sparks

Licensed Embalmer No. 3453

P. O. Address Cape Girardeau

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.