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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42389**

FILED DEC 18 1947

Registration District No. 218

Primary Registration District No. 4330

Registrar's No. 66

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

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town East Prairie mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town East Prairie mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CLARENCE B. LYNN

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married divorced married
6. (b) Name of husband or wife Maudie Lynn 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 1 1879
(Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace Mississippi Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired merchant

11. Industry or business _____

MOTHER FATHER
12. Name George D. Lynn
13. Birthplace Ill
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ophelia Small
15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Maudie Lynn

(b) Address East Prairie mo

17. (a) Burial (b) Date thereof Oct 21 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W. O. W. Cemetery

18. (a) Signature of funeral director Travis Shelby
(b) Address East Prairie mo

19. (a) 12-12-47 (b) Gertrude H. Harper
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 19
year 1947 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from Sept 9
1947 to Oct 19 1947
that I last saw him alive on Oct 19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion
Due to arterio-sclerosis

Due to _____

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

Major findings: 947
Of operations _____
Of autopsy _____

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? 0 (Specify type of place) (e) Means of injury _____

23. Signature AS Martin (M. D. or other) _____
Address East Prairie Date signed 10-28-47

716

RECEIVED

District Health Office No. 2,

District File Number 1247-1592

Date Filed 12-15-47

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 *Travis Shelby*

Licensed Embalmer No. 2726

P. O. Address East Prairie, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan 66
Registrar's No. 66

Registration District No. 218 Primary Registration District No. 4830

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town East Prairie
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Clarence B. Lynn
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Jan (Month) 1 (Day) 1947 (Year)

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

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name George D. Lynn

13. Birthplace Ill. (City, town, or county) _____ (State or foreign country)

14. Maiden name Mary Ophelia Small (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month _____ Day _____ Year 1947 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____

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

Major findings: Of operations _____ Of autopsy _____

Duration _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

42389