

No. 300
1-10-47
5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41644**
Registrar's No. **10986**

FILED JAN 11 1949 **318**

Registration District No. _____

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
911 So. Boyle Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **17**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **911 So. Boyle Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MARY LYNCH.**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **John Lynch** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **February 25 1860**
(Month) (Day) (Year)

8. AGE: Years **88** Months **9** Days **23** If less than one day
hr. _____ min. _____

9. Birthplace **?** **Kan.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **James Sullivan**

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

14. Maiden name **Catherine Maloy**

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

16. (a) Informant **Mrs. W.F. King**

(b) Address **911 S. Boyle Ave**

17. (a) **Burial** (b) Date thereof **Dec 21 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Jos. W. Clark**

(b) Address **1125 Hodiament Ave**

19. (a) **DEC 20 1948** (b) **J. B. Sasater**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **18**
year **1948** hour **6** minute **10** p/m.

21. I hereby certify that I attended the deceased from **8-5-48**
12-18-48 to **12-18-48**
that I last saw h. **er** alive on **12-16-48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Senility** Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)
some earlier of legs

Major findings: Of operations **Varicose Veins** PHYSICIAN _____

Of autopsy **NO** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: **710 710**

(a) Accident, suicide, or homicide (specify) **710**

(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? **NO** (Specify type of place) (e) Means of injury _____

23. Signature **J. B. Sasater** (M. D. or other) _____

Date signed **12-30-48**

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

MOTHER FATHER

Shect's 48

Dr. J.S.Scheets

2500 s Kingshighway

Laclede 3083

1-3 P.M.

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

Albert G. Hoyer

Licensed Embalmer No. *2971*

P. O. Address. *20 Lavis 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.