

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28302**
Registrar's No. **7118**

BIRTH-NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town or township) ST, Louis.		a. STATE Missouri b. COUNTY Mad	
c. LENGTH OF STAY (in days) 71 1/2		c. CITY (If outside corporate limits, write RURAL and give township) ST, Louis,	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary Hospital		d. STREET ADDRESS (If rural, give location) 5215 Maffitt	

3. NAME OF DECEASED a. (First) John		b. (Middle) Robert		c. (Last) Lynch		4. DATE OF DEATH (Month) (Day) (Year) Aug. 14, 1949	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 1, 1878	
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months Days		IF UNDER 12 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZENRY OF WHAT COUNTRY? 0	

13a. FATHER'S NAME John Lynch		13b. MOTHER'S MAIDEN NAME Fanne Jane Stevenson		14. NAME OF HUSBAND OR WIFE Roxcy Lynch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Roxcy Lynch ADDRESS Vandalia, Illinois	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia		INTERVAL BETWEEN ONSET AND DEATH 6 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Epilepsy		2 year	
		DUE TO (c) Psychosis, organic		19 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis, Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 30 ft	

22. I hereby certify that I attended the deceased from **July 8, 1948** to **Aug. 14, 1949**, that I last saw the deceased alive on **Aug. 14, 1949**, and that death occurred at **11:19 AM** from the causes and on the date stated above.

23a. SIGNATURE Charles F. Krag, M.D. (Degree or title)		23b. ADDRESS 5600 Armand St. St. Louis		23c. DATE SIGNED 15 Aug 1949	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-16-1949		24c. NAME OF CEMETERY OR CREMATORY Green Wood Cemetery	
				24d. LOCATION (City, town, or county) (State) VanBuren Burg, Illinois	

DATE REC'D BY LOCAL REG. AUG 16 1949		REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE Weick Bro. Und. Co. ADDRESS 2201 S. Grand Bl	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Female - dependent

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.....

..... Student Embalmer No.

working under my personal supervision.

Student,
Student Embalmer

Signed.....

James Robinson

Licensed Embalmer No. 4527

P. O. Address 2201 S Grand

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.