

## STANDARD CERTIFICATE OF DEATH

42719

State File No. 11087

FILED JAN 7 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JEFFERSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HOUSE SPRINGS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ENROUTE TO CHRISTIAN HOSPITAL		f. STREET ADDRESS ROUTE 2, BOX 241	
3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) A. c. (Last) LYNCH		4. DATE OF DEATH (Month) (Day) (Year) 12/23/49	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 12/18/1866
9. AGE (In years last birthday) 83		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE EDWARD F. LYNCH		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME MRS. HAZEL STROTHENKE, HOUSE SPRINGS MO.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Coronary Sclerosis</i> DUE TO (c) <i>Arterio sclerosis</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input 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) 97	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? H500		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:00 P. m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <i>Walter P. ...</i>		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 12/26/49		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 12/27/49		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	
24d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI		25. FUNERAL DIRECTOR'S SIGNATURE STROOT - CARROLL 4600 NATURAL BRIDGE AVE	
DATE REC'D BY LOCAL REG. DEC 26 1949		REGISTRAR'S SIGNATURE J. B. Lester	

