

*Approved*  
**FILED MAY 2 1950**

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**14244**

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **68**

1. PLACE OF DEATH a. COUNTY <b>St Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St Charles</b> )		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Charles</b>	
c. LENGTH OF STAY (in this place) <b>5 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>803 South Main St</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Joseph Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Louis</b> b. (Middle) c. (Last) <b>Lynch</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 17 1950</b>
---	---

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 19 1912</b>	9. AGE (In years last birthday) <b>38</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	11. BIRTHPLACE (State or foreign country) <b>Warren County Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--------------------	-------------------------------	---	--------------------------------------	---	---	---	---

13a. FATHER'S NAME <b>Renzey Lynch</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Polston</b>	14. NAME OF HUSBAND OR WIFE <b>Hazel Thompson Lynch</b>
--	---	---

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. <b>492-01-9447</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Hazel Lynch</b>	ADDRESS <b>803 So. Main St</b>
--	--	--	--------------------------------

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uremia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>  <b>5 years?</b>  <b>446X</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>nephrosclerosis</b>		
	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 checked="" 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)
--	--	---

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?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **3/15, 1950**, to **4/17, 1950**, that I last saw the deceased alive on **4/17, 1950**, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>George E. Kister</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>St Charles Mo</b>	23c. DATE SIGNED <b>4-20-50</b>
--	-----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>April 19 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St Charles Mo.</b>
---	--------------------------------	--	---

DATE REC'D BY LOCAL REG. <b>4-26-50</b>	REGISTRAR'S SIGNATURE <b>James Hamilton</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Richardson</b>	ADDRESS <b>Gene OX @ hanks 24</b>
---	---	--	-----------------------------------

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

0923

0923  
0

RECEIVED  
APR 29 1950  
District Health Officer No. 9,  
District File Number

**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 *Arthur C. Jones*

Licensed Embalmer No. 3115

P. O. Address *A. Charles Mc*

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.