

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17414

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 82

1. PLACE OF DEATH a. COUNTY <i>Livingston</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.) a. STATE <i>Missouri</i> b. COUNTY <i>Callaway</i>	
b. CITY OR TOWN <i>Chillicothe</i>		c. CITY OR TOWN <i>HAMILTON</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Henderson Nursing Home</i>		d. STREET ADDRESS <i>No Other Address</i>	

3. NAME OF DECEASED (Type or Print) a. (First) <i>Joshua</i>	b. (Middle) <i>W</i>	c. (Last) <i>Lynch</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>Mar 29 1950</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Apr 28 1886</i>	9. AGE (In years last birthday) 83 8 1
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10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <i>Farming</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Stock Raising</i>	11. BIRTHPLACE (State or foreign country) <i>Davies Co. Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
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13a. FATHER'S NAME <i>Thomas Lynch</i>	13b. MOTHER'S MAIDEN NAME <i>Mary A Moore</i>	14. NAME OF HUSBAND OR WIFE <i>Harriet Lynch</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT'S SIGNATURE OR NAME <i>Mrs J B Robertson</i>	ADDRESS <i>HAMILTON Mo</i>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <i>410X</i>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>mitral stenosis</i>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	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"/>
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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 *Oct 1*, 1944, to *Mar 29*, 1950, that I last saw the deceased alive on *Mar 20*, 1950, and that death occurred at *2 P* m., from the causes and on the date stated above.

23a. SIGNATURE <i>J M Robertson</i>	(Degree or title) <i>M.D.</i>	23b. ADDRESS <i>Chillicothe Mo</i>	23c. DATE SIGNED <i>Mar 29 1950</i>
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24. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <i>Mar 31 1950</i>	24c. NAME OF CEMETERY OR CREMATORY <i>McCrory Cem</i>	24d. LOCATION (City, town, or county) (State) <i>Davies Co. Mo</i>
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DATE REC'D BY LOCAL REG. <i>Mar 29 1950</i>	REGISTRAR'S SIGNATURE <i>Frances B Neale</i>	191	2. FUNERAL DIRECTOR'S SIGNATURE <i>Trull Funeral Home</i>	ADDRESS <i>HAMILTON</i>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Signed.....
Student Embalmer

Signed Morris A. Brun

Licensed Embalmer No. 03918

P. O. Address Hamilton

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.