

FILED JUL 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24943

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5653**

1. PLACE OF DEATH a. COUNTY 1		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY	
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 St Louis 2219	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1425-N-21	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1425 N 21			

3. NAME OF DECEASED (Type or Print) LYDIA			4. DATE OF DEATH (Month) (Day) (Year) 6-18-51			
a. (First)	b. (Middle)		c. (Last) LYNCH			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 5-14-1881	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ala		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Jacob White		13b. MOTHER'S MAIDEN NAME Nancy Popell		14. NAME OF HUSBAND OR WIFE Alfred Lynch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Harde Lynch ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		DUE TO (b) Hypertension				
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)				
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		II. OTHER SIGNIFICANT CONDITIONS				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? fall	

22. I hereby certify that I attended the deceased from **May 23, 1951**, to **June 18, 1951**, that I last saw the deceased alive on **June 3, 1951**, and that death occurred at **11:20 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Xa Cadene A Hill MD		23b. ADDRESS 1417 Franklin		23c. DATE SIGNED 6-19-51	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-23-51		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St Louis, Mo		25. FUNERAL DIRECTOR'S SIGNATURE QD Richardson		ADDRESS 225 W. 11th	
DATE REC'D BY LOCAL REG. JUN 22 1957		REGISTRAR'S SIGNATURE J. B. Larater			

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

2168
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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.....

working under my personal supervision.

Student Embalmer No.....

Signed

AD Richardson

Signed.....

Student Embalmer

Licensed Embalmer No. 2928

P. O. Address. 2625 Glasgow

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.