

FILED OCT 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30810**

BIRTH NO. _____ REG. DIST. NO. **200** PRIMARY REG. DIST. NO. **5724** Registrar's No. **97**

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Jackson	
b. CITY OR TOWN Rural-Eagle		c. CITY OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 3 mos.		d. STREET ADDRESS (If rural, give location) 3117 Wayne	
d. FULL NAME OF HOSPITAL OR INSTITUTION 9 mi NE of Macon			

3. NAME OF DECEASED (Type or Print) a. (First) Annie b. (Middle) M. c. (Last) Lynch			4. DATE OF DEATH (Month) (Day) (Year) Sept. 10 1951		
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5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Apr. 26, 1886		9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Pontwater, Mich.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME John Mettes			13b. MOTHER'S MAIDEN NAME Halkschapel			14. NAME OF HUSBAND OR WIFE Wm. H. Lynch		
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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 Wm. H. Lynch		ADDRESS Kansas City	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 1 day	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertension							
		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 none		19b. MAJOR FINDINGS OF OPERATION none				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) 331x	
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? _____	

22. I hereby certify that I attended the deceased from **1 Sept**, 19**51**, to **10 Sept**, 19**51**, that I last saw the deceased alive on _____, 19____, and that death occurred at **10:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Donald E. Eggleston M.D.		23b. ADDRESS Macon, Mo.		23c. DATE SIGNED 14 Sept 51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/13/51		24c. NAME OF CEMETERY OR CREMATORY St. Marys		24d. LOCATION (City, town, or county) (State) Macon Mo.	
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DATE REC'D BY LOCAL REG. 10/5/51		REGISTRAR'S SIGNATURE Ruth Mcneely		25. FUNERAL DIRECTOR'S SIGNATURE Albert Skinner		ADDRESS Macon	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 10.11.51
MACON COUNTY HEALTH DEPARTMENT
County File No. 10.51.167
Date Filed 10.11.51

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 Thos. Z. Both

Licensed Embalmer No. 4552

P. O. Address Macon, Mo.

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.