

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

State File No. **44152**

No. 300
10. 48

DATE OF DEATH **JAN 8, 1952** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **506** Registrar's No. **3321**

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

1. PLACE OF DEATH a. COUNTY ST. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Manchester Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Manchester 46000	
c. LENGTH OF STAY (in this place) 7 yrs.		d. STREET ADDRESS (If rural, give location) Pine Crest Home Dist. II	
d. FULL NAME OF HOSPITAL OR INSTITUTION		4. DATE OF DEATH (Month) (Day) (Year) 1-7-52	
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Lynn c. (Last) Lynn		5. SEX Female	
6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	
8. DATE OF BIRTH Feb. 8-1866		9. AGE (in years last birthday) 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tailor		10b. KIND OF BUSINESS OR INDUSTRY tailoring	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Charles Lynn		13b. MOTHER'S MAIDEN NAME unknown	
14. NAME OF HUSBAND OR WIFE unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Pine Crest Home	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute cardiac dilatation		INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES		DUE TO (b) Chronic myocarditis	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) 4222	
II. OTHER SIGNIFICANT CONDITIONS		DUE TO (c) Blindness bilateral 6 mo.	
Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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?	
22. I hereby certify that I attended the deceased from 6-1, 1950, to Dec. 26, 1951 , that I last saw the deceased alive on 12/24, 1951 , and that death occurred at 12:50 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or Title) A. Theslie, M.D.		23b. ADDRESS Kirkwood, Mo.	
23c. DATE SIGNED 12/31/51		24a. BURIAL, CREMATION, REMOVAL (Specify) Anatomical	
24b. DATE 12-31-52		24c. NAME OF CEMETERY OR CREMATORY St. Louis, Mo.	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	
DATE REC'D BY LOCAL REG. 12-31-52		REGISTRAR'S SIGNATURE Herbert R. Domb	
25. FUNERAL DIRECTOR'S ADDRESS 4104 Manchester Ave.			

(Licensed Embalmer's Statement on Reverse Side)

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 *W. Embalm*

Licensed Embalmer No. _____

P. O. Address *Atank*

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.