

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6094
788

State File No.

FILED FEB 27 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City	c. LENGTH OF STAY (In this place) 5 Mo	c. CITY (If outside corporate limits, write RURAL and give township) Independence	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6033 Rockhill Rd.		d. STREET ADDRESS (If rural, city location) 321 S. Liberty St.	

3. NAME OF DECEASED (Type or Print) MISS. CECILIA	a. (First)	b. (Middle)	c. (Last) LYNCH	4. DATE OF DEATH (Month) (Day) (Year) Feb. 5, 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 1873 03-24-1872	9. AGE (In years last birthday) 80 79	If UNDER 1 YEAR Months Days	If UNDER 1 HR. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Independence, Mo. 0	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Lynch	13b. MOTHER'S MAIDEN NAME Sarah Brady	14. NAME OF HUSBAND OR WIFE -----
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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 Miss. Anna Lyons	ADDRESS K.C. Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 490h
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia		
	ANTECEDENT CAUSES Morbid 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. Arteriosclerotic heart disease			

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) Natural	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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?
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22. I hereby certify that I attended the deceased from 4-20, 1952, to 2-5, 1953, that I last saw the deceased alive on 2-5, 1953, and that death occurred at 6:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE H. H. Owens (Degree or title)	23b. ADDRESS 1034 Bealton Bldg	23c. DATE SIGNED 2-6-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 7, 1953	24c. NAME OF CEMETERY OR CREMATORY St. Mary's	24d. LOCATION (City, town, or county) (State) Indep. Mo.
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DATE REC'D BY LOCAL REG. 2-6-53	REGISTRAR'S SIGNATURE Heraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE W. H. Mitchell	ADDRESS Indep, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 me

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working under my personal supervision.

Student Embalmer No.

Signed Henry S. Mitchell

Signed.....
Student Embalmer

Licensed Embalmer No. 3725

P. O. Address Rand 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.