

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

State File No. **279**
Registrar's No. **116**

BIRTH NO. **422-54** FILED FEB 8 1954 REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY BUCHANAN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY North	
b. CITY OR TOWN ST. JOSEPH, MO		c. CITY OR TOWN rural - North	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) 1130	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital			

3. NAME OF DECEASED (Type or Print) RICKY LYNN LYNCH			4. DATE OF DEATH (Month) (Day) (Year) Feb 1 1954			
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		
8. DATE OF BIRTH Jan 31, 1954		9. AGE (In years last birthday) 1		10. CITIZEN OF WHAT COUNTRY? USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) St. Joseph, Mo.		

13a. FATHER'S NAME DALE LYNCH		13b. MOTHER'S MAIDEN NAME PAULINE WOOD		14. NAME OF HUSBAND OR WIFE None	
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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 Dale Lynch	
				ADDRESS North MO	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Failure		ANTECEDENT CAUSES 7 Pulvered Clouse		1 day	
		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) 776 X	
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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 31-1954, to 2-1-1954, that I last saw the deceased alive on 2-1-1954, and that death occurred at 9 A M, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Charles J. McAllister D.O.		23b. ADDRESS Century Mo		23c. DATE SIGNED 2-2-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb 1-1954		24c. NAME OF CEMETERY OR CREMATORY Knox Cemetery	
				24d. LOCATION (City, town, or county) (State) Century Mo	

DATE REC'D BY LOCAL REG. Feb 4, 1954		REGISTRAR'S SIGNATURE Arthur M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE K.R. Brann	
				ADDRESS Donner Mo	

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 _____

not embalmed

working under my personal supervision.

Student Embalmer No.

Signed *J.P. Brown*

Signed.....
Student Embalmer

Licensed Embalmer No. *2947*

P. O. Address. *Brown mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.