

STANDARD CERTIFICATE OF DEATH

State File No. 11869

BIRTH NO. _____ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 3023 Registrar's No. 5.

1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri COUNTY Benton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clinton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Warsaw	
c. LENGTH OF STAY (in this place) 8 days		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Clinton General Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) John Lynn b. (Middle) H. c. (Last) Lynn			4. DATE OF DEATH (Month) (Day) (Year) April 20, 1954		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH July 11, 1891		9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Fairfield Missouri	
				12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME George W. Lynn		13b. MOTHER'S MAIDEN NAME Melissa Bristeen		14. NAME OF HUSBAND OR WIFE Mabel Lynn	
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. 494-18-4343		17. INFORMANT'S SIGNATURE OR NAME Mabel Lynn, Warsaw Missouri	

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				INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of Lung					
		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.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		163x	
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 April 11, 1954, to April 20, 1954, that I last saw the deceased alive on April 20, 1954, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE James Smith M.D.		23b. ADDRESS Clinton, Missouri		23c. DATE SIGNED 4-22-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-23-54		24c. NAME OF CEMETERY OR CREMATORY Osceola	
				24d. LOCATION (City, town, or county) (State) Osceola Missouri	

DATE REC'D BY LOCAL REG April 23-54		REGISTRAR'S SIGNATURE Florence Adair		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
				J. J. ...		Osceola Mo	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola, 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.