

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26414

State File No.

FILED SEP 1 1954

BIRTH NO. REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 453

1. PLACE OF DEATH a. COUNTY <u>Butler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY OR TOWN <u>Campbell</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Doctors Hospital</u>				STREET ADDRESS (If rural, give location) <u>2350 1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROSA</u> b. (Middle) <u>LEE</u> c. (Last) <u>LYNN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 14 1954</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 23, 1873</u>		9. AGE (In years last birthday) <u>81</u>	If UNDER 1 YEAR Months <u>4</u> Days <u>21</u>	If UNDER 24 HRS. Hours <u>0</u> Min. <u>21</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Clarkton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>W. H. Shelton</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jane Wright</u>		14. NAME OF HUSBAND OR WIFE <u>James W. Lynn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J. W. Lynn, Campbell, Mo.</u>			
MEDICAL CERTIFICATION							
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.						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Toxemia</u>							
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a), stating the underlying cause last.							
DUE TO (b) <u>Intestinal Obstruction</u>						<u>8 days</u>	
DUE TO (c) <u>Postoperative Adhesions 3 days postoperative</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Myocarditis & Auricular Fibrillation</u>						<u>5705</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Postoperative adhesions & 14 in. gangrenous ileum</u>				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)			
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 <u>8-11</u> , 1954, to <u>8-14</u> , 1954, that I last saw the deceased alive on <u>8-14</u> , 1954, and that death occurred at <u>10:35 AM</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>Poplar Bluff, Mo</u>		23c. DATE SIGNED <u>8-20-54</u>	
24a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>		24b. DATE <u>Aug. 16, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Campbell, Missouri</u>		
DATE RECD BY LOCAL HEALTH OFFICER		REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>48970</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Landess Funeral Home, Campbell, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
AUG 30 1954

BUTLER CO. HEALTH CENTER

FILE No. _____

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.....
Signature of Student Embalmer

Signed *Christina M. Landes*.....

Licensed Embalmer No. *4527*.....

P. O. Address *Campbell*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.