

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43797**
Registrar's No. **11330**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Charles | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | c. LENGTH OF STAY (in this place) 2 wks | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital | | e. STREET ADDRESS (If rural, give location) Missouri 0923 | |

| | | | |
|--|-------------|------------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Josephine | b. (Middle) | c. (Last) Lynch | 4. DATE OF DEATH (Month) (Day) (Year) 12 - 11 - 1954 |
|--|-------------|------------------------|--|

| | | | | |
|----------------------|----------------------------------|---|---|--|
| 5. SEX Fem | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH 10 - 17 - 1879 | 9. AGE (In years last birthday) 75 If UNDER 1 YEAR: Months Days Hours Min. |
|----------------------|----------------------------------|---|---|--|

| | | | |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | 10b. KIND OF BUSINESS OR INDUSTRY At home | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|---|--|--|

| | | |
|--|---|-----------------------------|
| 13a. FATHER'S NAME Florenz Lynch | 13b. MOTHER'S MAIDEN NAME Anna Hanlon | 14. NAME OF HUSBAND OR WIFE |
|--|---|-----------------------------|

| | | | |
|---|--|--|-------------------------------------|
| 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 Chester Buehre | ADDRESS 732 Florence Ave. |
|---|--|--|-------------------------------------|

| | | | |
|---|--|--|----------------------------------|
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* ANTECEDENT CAUSES Communicated inter cond. sub. trochanteric fracture of left femur; Arterio sclerosis; suffered in fall in Nursing Home in St Charles Mo., on November 29, 1954, about 1200 hours | | |
| 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 Accident | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|---|--|

| | | |
|---|---|---|
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) Nursing Home | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Charles Mo 130 |
|---|---|---|

| | | |
|---|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov 29 1954 12 NOON | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? E9047 |
|---|--|--|

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **9:40P.**, from the causes and on the date stated above. **45**

| | | | |
|--|-------------------|-----------------------------------|-------------------------------------|
| 22a. SIGNATURE Patrick Taylor Carraway | (Degree or title) | 22b. ADDRESS 1300 Clark | 22c. DATE SIGNED 12/15/54 |
|--|-------------------|-----------------------------------|-------------------------------------|

| | | | |
|--|------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 12/15/54 | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis, Missouri |
|--|------------------------------|---|---|

| | | | |
|--|---|--|------------------------------------|
| DATE REC'D BY LOCAL REG. DEC 13 1954 | REGISTRAR'S SIGNATURE J. Earl Smith, M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral | ADDRESS 1905 Union Blvd. |
|--|---|--|------------------------------------|

S.P. (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
Signature of Student Embalmer

Signed *Warren A. Carver*

Licensed Embalmer No. *35*

P. O. Address

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.