

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32216

STATE FILE NUMBER

8027

FILED SEP 21 1956

318

1003

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1.</b>		Length of stay in 1b <b>7/6/56</b> STREET ADDRESS <b>3400 S. Grand Blvd.</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWIN</b> Middle <b>Henry</b> Last <b>LYNCH</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>29</b> , Year <b>1956</b>	
5. SEX <b>Male</b> <input type="radio"/>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1891</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <b>65</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	10c. AGE (In years last birthday) <b>65</b>
11. BIRTHPLACE (City and state or country) <b>Dixon, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Lynch</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Mc Marron</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Thomas F. Lynch</b>		Address <b>RT. 4, Ferncliff, St. Charles Mo.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal Hemorrhage</b> DUE TO (b) <b>Retroperitoneal Hematoma secondary to perforation prostatic capsule following transurethral resection</b> DUE TO (c) <b>Benign Prostatic Hypertrophy</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>610 X</b>
20c. TIME OF INJURY Hour - Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>8/27/56</b> to <b>8/29/56</b> and last saw her him alive on <b>8/29/56</b> Death occurred at <b>8:20 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Ronald Y. Seiver MD</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	
22c. DATE SIGNED <b>8/30/56.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/31/56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, &amp; Mo</b>
24. FUNERAL DIRECTOR <b>John H. Gebken Sons</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 30 1956</b>	
ADDRESS <b>2630 Gravois Ave.</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

300 1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Robert T. Gibbs*

Licensed Embalmer No.. ~~4144~~

P. O. Address.. 2630. Gravel

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If not 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.