THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 2919

FILED FEB 4 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 528

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSPITAL #1 — Length of stay in 1b: 25 1.30

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: St. Charles
c. CITY OR TOWN: St. Charles 0923 — Inside Limits Yes ☐ No ☐
STREET ADDRESS (If outside, give location): 2300 N. 5th St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle Last LYNCH
4. DATE OF DEATH: Month JAN. Day 16 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Feb. 11, 1885
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (City and state or country): Warrenton, Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas Polson
14. MOTHER'S MAIDEN NAME: Nancy Rattles
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Jessie Lynch Address: 2300 N. 5th St. Charles, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL VASCULAR THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): GENERALIZED ARTERIAL SCLEROSIS
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 332x
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1/13/57, to 1/16/57 and last saw her alive on 1/16/57
Death occurred at 1:20 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: G. G. Mogaletta (Degree or title) M.D.
22b. ADDRESS: 1515 LAFAYETTE AVE,
22c. DATE SIGNED: 1/16/57

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 1-19-57
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Cemetery
23d. LOCATION (City, town, or county) (State): St. Charles, Mo.

24. FUNERAL DIRECTOR: H.C. Dallmeyer & Sons ADDRESS: St. Charles, Mo.
25. DATE REC'D BY LOCAL REG.: JAN 17 '57
26. REGISTRAR'S SIGNATURE: J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

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

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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.