ealth,
Welfare
ublic
ervice

300
1-56

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

FILED FEB 26 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

6425

STATE FILE NUMBER 1370

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

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hosp #1 — Length of stay in hospital 25	d. STREET ADDRESS (If outside, give location) 1445 Hoaidmont — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Giles Middle: Lynch Last:	4. DATE OF DEATH Month Day Year: Febuary 7, 1957		
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 5-22-1910
9. AGE (In years last birthday): 46	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): arc welder	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (City and state or country): New Liberty, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Pete Lynch		14. MOTHER'S MAIDEN NAME: Anna Lynch	
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.: 359-01-2028	17. INFORMANT: Maggie Lych, 1445 Hoaidmont (Address)	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchogenic Carcinoma

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 162x

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 1/9/57 to 2/7/57 and last saw her/him alive on 2/7/57

Death occurred at 7:25pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Harold M. Gutman, M.D.	22b. ADDRESS: 1515 Lafayette	22c. DATE SIGNED: 2-10-57
23a. BURIAL, CREMATION, REMOVAL (Specify): removal	23b. DATE: 2-9-57	23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Paducah, Ky.		
24. FUNERAL DIRECTOR: Kennedy, Paducah, Ky.	ADDRESS	25. DATE RECD. BY LOCAL REG.: FEB 11 57
26. REGISTRAR'S SIGNATURE: Earl Smith MD		

(Licensed Embalmer's Statement on Reverse Side)

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 Homer W. Fri

Licensed Embalmer No. 3

P. O. Address St. Lo

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.