

Health, Welfare, Public Service

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32006

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4153

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u> 579
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DEAD ON ARRIVAL K.C. GENERAL HOSPITAL</u>		Length of stay in lb <u>63 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>3827 MONROE AVE.</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>WARREN</u> Middle <u>WILLIAM</u> Last <u>LYNCH</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>2</u> Year <u>1957</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG-28-1894</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESSMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>KANSAS CITY STAR</u>	11. BIRTHPLACE (City and state or country) <u>KANSAS CITY MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>THOMAS W. LYNCH</u>	13b. MOTHER'S MAIDEN NAME <u>MINNIE FOWLER</u>	14. NAME OF HUSBAND OR WIFE <u>MRS. NELLIE BLANCHE LYNCH</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR I</u>	16. SOCIAL SECURITY NO. <u>486-09-1795</u>	17. INFORMANT <u>MRS. NELLIE BLANCHE LYNCH</u> Address <u>3827 MONROE AVE. KANSAS CITY, MO.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterial Hypertension</u>	<u>6 years</u>
	DUE TO (c)	<u>331 X</u>
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? <u>6</u> YES <input 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.)
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20c. TIME OF INJURY Hour <u>8:00 P.</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT <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 <u>KANSAS CITY</u>	COUNTY <u>MO.</u>	STATE <u>MO.</u>
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21. I attended the deceased from <u>1951</u> to <u>Sept. 2, 1957</u> and last saw <u>her</u> alive on <u>July 11, 1959</u> Death occurred at <u>8:00 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22. SIGNATURE <u>Kenneth A. Davis, M.D.</u> (Degree or title)	22b. ADDRESS <u>1211 Plaza Theater Bldg. Kansas City, Mo.</u>	DATE SIGNED <u>9-3-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT. 5, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
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24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>9-5-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Kenneth A. Davis

All diseases in Part I must be causally related.

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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 *Chester K. Brown*

Licensed Embalmer No. *493*

P. O. Address *K.C.N.*

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.