

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3243

FILED JAN 17 1958

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **171**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>NEWBURG, MO</b>	
c. LENGTH OF STAY (In this place) <b>2 DAYS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>FRISCO EMPLOYEES HOSPITAL</b>		* STREET ADDRESS (If rural, give location) <b>0810</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Harold</b>	b. (Middle) <b>Charles</b>	c. (Last) <b>Lynch</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JAN. 7, 1958</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-22-1898</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.O.Y.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Newburg, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>JOHN</b>	13b. MOTHER'S MAIDEN NAME <b>MARY TOWELL</b>	14. NAME OF HUSBAND OR WIFE <b>IRENE ROOT</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WORLD WAR I</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Wife Irene Root Lynch</b>	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of transverse Colon with obstruction of colon</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk + 1 day? 2 days?</b>
	ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) starting the underlying cause last.</b>		
	DUE TO (b) <b>Rupture of Cecum</b> <b>peritonitis</b>		
DUE TO (c)		153.1	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>1-6-58</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of transverse Colon and as above</b>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **1-5-** 19**58**, to **1-7-** 19**58**, that I last saw the deceased alive on **1-6-** 19**58**, and that death occurred at **3-A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Norman Miller MD</b>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>4960 Laclede Ave</b>	23c. DATE SIGNED <b>1-7-58</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>1-8-58</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Newburg</b>	24d. LOCATION (City, town, or county) (State) <b>Newburg, Mo</b>
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DATE REC'D BY LOCAL REG. <b>JAN 7 58</b>	REGISTRAR'S SIGNATURE <b>Joseph Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington</b>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Robert M. Murray*.....

*3749*  
Licensed Embalmer No.....

P. O. Address *St. Louis*.....

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.