

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014305
STATE FILE NUMBER

FILED APR 22 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1643

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's		d. STREET ADDRESS 912 E. 30th St.	
3. NAME OF DECEASED (Type or print) First MARY Middle GWENDOLYN Last LYNCH		4. DATE OF DEATH Month 3 Day 27 Year 58	
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Drug	11. BIRTHPLACE (City and state or country) Butte, Montana
13a. FATHER'S NAME Chas. W. Fisher		14. NAME OF HUSBAND OR WIFE Marcus Filmore Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address Mrs. J. B. Ehrsam, 600 W. 59th Terr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Syphilitic toxemia & bacteremia			INTERVAL BETWEEN ONSET AND DEATH 24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Extensive cellulitis of left shoulder			60 hrs
DUE TO (c) & upper left chest			1928-
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 type="checkbox"/> NO <input checked="" 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.)	
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 3-26-'58 to 3-27-'58 and last saw her alive on 3-26-58 Death occurred at 6:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title) MD		22b. ADDRESS 701 E 63rd K.C. Mo	
		22c. DATE SIGNED 3/28/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-31-58	
23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Wagner Funeral Home K C Mo		25. DATE RECD. BY LOCAL REG. 3-29-58	
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

E. A. QIGER

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 

Licensed Embalmer No. 4795

P. O. Address R. E. 31

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.