

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015127  
STATE FILE NUMBER

FILED MAY 12 1958

Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 129

300  
1-57

7428

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Nodaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryville</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Parnell</u> <u>0749</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hospital</u>		Length of stay in lb <u>1 da</u>	d. STREET ADDRESS (If outside, give location) <u>1 da</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>PHYLLIS</u> Middle <u>ROSALLE</u> Last <u>LYNCH</u>			4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1958</u>		
5. SEX <u>female</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>10-10-1928</u>		9. AGE (In years) <u>29</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during life, or state if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR <u>homemaking</u>	11. BIRTHPLACE (City and state or country) <u>Clyde, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Roy Merrigan</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Spire</u>		14. NAME OF HUSBAND OR WIFE <u>Paul Lynch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no (unknown)</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT Address <u>Paul Lynch, Parnell, Mo</u>		

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>A fibrinogenemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
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) <u>Caesarian section #6</u>		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 <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 <u>11-2-57</u> to <u>5-3-58</u> and last saw her/him alive on <u>5-3-58</u> Death occurred at <u>4 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE <u>H. C. Bauman M.D.</u> (Degree or title)		22b. ADDRESS <u>Maryville Mo</u>		22c. DATE SIGNED <u>5/8/58</u>	
23a. BURIAL, CREMATION, REPOSING <u>burial</u>		23b. DATE <u>5/6/1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Columba Cemetery</u>	
				23d. LOCATION (City, town, or county) (State) <u>Conception, Mo.</u>	

24. SPECIAL DIRECTOR ADDRESS <u>Maryville Mo</u>		25. DATE RECD. BY LOCAL REG. <u>5-10-58</u>		26. REGISTRAR'S SIGNATURE <u>Bess L. Ball</u>	
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(Lic. of Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

MEDICAL CERTIFICATION

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 *G. M. Atkinson* .....

Licensed Embalmer No. *3379* .....  
P. O. Address *Mayville* .....

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.