

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003228  
STATE FILE NUMBER  
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LED JAN 28 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>702 CHOUTEAU AVE</u>		Length of stay in lb d. STREET ADDRESS (If outside, give location) <u>702 CHOUTEAU</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIS F LYNN</u>		4. DATE OF DEATH Month Day Year <u>JAN 14 1959</u>	
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>MAR 15 1904</u>
9. AGE (In years last birthday) <u>54</u>		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) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>		13a. FATHER'S NAME <u>WALTER LYNN</u>	
13b. MOTHER'S MAIDEN NAME <u>MARTHA CABE</u>		14. NAME OF HUSBAND OR WIFE <u>TERESA LYNN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>TERESA LYNN 702 CHOUTEAU</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>Carcinoma of the Lung</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>163X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 mo.</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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>11-12-57</u> to <u>1-14-59</u> and last saw her alive on <u>1-10-59</u> Death occurred at <u>1-14-59</u> in on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <u>William A. Turner MD</u>		22b. ADDRESS <u>4401 Hampton</u>	22c. DATE SIGNED <u>1-15-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN 16 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER &amp; PAUL</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kutis 2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 15 '59</u>	26. REGISTRAR'S SIGNATURE <u>Charles Smith MD</u> <u>—mjb</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1-330 P.M. 9/20/41

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 E. Euan Poince \_\_\_\_\_

Licensed Embalmer No. 3403 \_\_\_\_\_

P. O. Address Spring 7 \_\_\_\_\_

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.