RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

D VS DEC 23 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11923 STATE FILE NUMBER 60-047705

DED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Length of stay in 1b: 8 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: LUTHERAN HOSPITAL — Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 3621 MINNESOTA AVENUE — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First SAMUEL Middle O. Last LYNNE.
4. DATE OF DEATH: Month DECEMBER Day 10, Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE.
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 12/24/1892
9. AGE (last birthday): 67
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSURANCE AGENT
10b. KIND OF BUSINESS OR INDUSTRY: RELIABLE INS. CO.
11. BIRTHPLACE (City and state or country): KENTUCKY
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: JONATHAN LYNNE
13b. MOTHER'S MAIDEN NAME: ARMINDA WALKER
14. NAME OF HUSBAND OR WIFE: MELVILLE WILLIAMS LYNNE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: 495 14 3511 A
17. INFORMANT: MELVILLE LYNNE Address: 3621 MINNESOTA AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 332x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 December 5, to Dec 10 '60 and last saw her/him alive on Dec. 10, 1960
Death occurred at 9 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. a. Nussbaum MD (Degree or title)
22b. ADDRESS: 3701 Grandel Sq
22c. DATE SIGNED: 12-12-60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: Dec. 14, 1960
23c. NAME OF CEMETERY OR CREMATORY: ST. TRINITY CEMETERY
23d. LOCATION (City, town, or county) (State): LEMAY, MISSOURI

24. FUNERAL DIRECTOR: C. HOFFMEISTER MORTUARIES ADDRESS: 7814 SO. BROADWAY ST. LOUIS, MO.
25. DATE RECD. BY LOCAL REG.: DEC 12 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Louis C. Hoffmeist

Licensed Embalmer No. 3871

P. O. Address 7814 S. 13

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.