

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019887

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 64

FILED MAY 16 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0850

2 0850

3 2

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fort Leonard Wood		c. CITY OR TOWN Fort Leonard Wood	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital		d. STREET ADDRESS (If outside, give location) 3 Delafield	
3. NAME OF DECEASED (Type or print) First ANN Middle ELIZABETH Last LYNCH		4. DATE OF DEATH Month May Day 7 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months - Days 2 Hours - Min. -
11a. BIRTHPLACE (City and state or country) Ft Leonard Wood, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Homer M. Lynch		13b. MOTHER'S MAIDEN NAME Catherine E. Wedge	
14. NAME OF HUSBAND OR WIFE -		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Homer M. Lynch Address 3 Delafield Ft Leonard Wood, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Tracheo-Esophageal Fistula Mongolism DUE TO (c) Multiple Congenital Abnormalities			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hydrocephalus, Hip Displasia, Paraplegia			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 May 5, 1962 to May 7, 1962 and last saw her xxx alive on May 7, 1962 Death occurred at 8:05 P. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE William T. Repasky, Capt, MC WILLIAM T. REPASKY, Captain, MC		22b. ADDRESS US Army Hospital Fort Leonard Wood, Missouri	22c. DATE SIGNED 5-8-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/8/1962	23c. NAME OF CEMETERY OR CREMATORY Hindistan Cemetery	23d. LOCATION (City, town, or county) (State) Bloomington Ind
24. FUNERAL DIRECTOR Moss-Williams Waynesville, MO		25. DATE RECD. BY LOCAL REG. 5-8-62	26. REGISTRAR'S SIGNATURE Paula Mae Anderson

MAY 17 1962

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 Clarence Moss

Licensed Embalmer No. 4896

P. O. Address Waymerville, MO

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.