

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

BUREAU OF THE CENSUS
FILED MAY 25 1945
111

Registration District No. _____

Primary Registration District No. 5427

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Robertsville mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Calvary Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 36
(c) City or town ROBERTSVILLE Mo 11
(If outside city or town limits, write "RURAL")
(d) Street No. Rural - Calvary Hosp
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charley L. Lynch

3. (b) If veteran, name war _____ No
(c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 26th 1886 1876
(Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace West Virginia, (City, town, or county) (State or foreign country)

10. Usual occupation Insurance

11. Industry or business _____

12. Name Hiram Lynch
13. Birthplace West Virginia (City, town, or county) (State or foreign country)
14. Maiden name Eleanor Williams
15. Birthplace Not Known (City, town, or county) (State or foreign country)

16. (a) Informant Helen Judge
(b) Address Glen Summit Springs, Pa.

17. (a) Burial (b) Date thereof May, 13, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sullivan, Mo.

18. (a) Signature of funeral director J. P. Williams
(b) Address Sullivan, Mo.

19. (a) 5/12/45 (b) Stanley C. Pletcher
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10th year 1945 hour 8 minute 9 am.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture Skull Fore head arm broke Leg Broke
Due to accident freight train hitting car he was driving.
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy none 1700

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence May 10th 1945
(c) Where did injury occur Robertsville Franklin mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Rail Road Crossing
While at work? (Specify type of place) (e) Means of injury Driving
23. Signature E. F. Ottomano (M.D. or other) 3/12/1945
Address Union mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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OCT 23 1947

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed: 5-24-45

MAY 24 1945

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

J. T. Williams

Licensed Embalmer No. 427

P. O. Address Sullivan, 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 this body is not embalmed, fact should be so stated above.