

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

24303

1. PLACE OF DEATH

County Greene
Township Springfield Mo.
City Springfield Mo. (No. St. John Hospital)

Registration District No. 518
Primary Registration District No. 518

File No. 481
Registered No. 481
St. St. John Hospital Ward

2. FULL NAME

(a) Residence. No. St. Ward. St. John Hospital
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 14 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 9 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Shelbyville
(STATE OR COUNTRY) Ind.

10. NAME OF FATHER John Lyons

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Kate McBride

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)

14. INFORMANT Rosa A. Bastian
(Address) 923 S. 8th St. Springfield Mo

15. JUL 3 1920 FILED Clara F. Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 3rd 1920

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1920, to July 3rd, 1920
That I last saw h. alive on June 30, 1920, and that death occurred, on the date stated above, at 8:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular disease
operation below
funeral attended

CONTRIBUTORY (SECONDARY) not
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signature) J. H. Freese M. D.
7/3, 1920 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Shelbyville Ind. DATE OF BURIAL 7-4-1920

20. UNDERTAKER Cayson Ind. Co. ADDRESS 400 South 1st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

