

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

Do not use this space.

18389

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township New Primary Registration District No. _____ Registered No. 2092
 City Kansas City (No. General Hosp) _____ St. 3 Ward)

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Unknown</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE <u>about 50</u>	YEARS	MONTHS
	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) <u>Don't know</u> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <u>Don't know</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Don't know</u> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <u>Don't know</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Don't know</u> (STATE OR COUNTRY)	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 15 1927

17. I HEREBY CERTIFY that I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Endocarditis
92A
12A
900
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

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

8 Did an operation precede death? _____ DATE OF _____
 WAS THERE AN AUTOPSY? Yes
 WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) Thos Nelson, M. D.
6-16-1927 Address General Hospital

*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.

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.

14. INFORMANT Oleon E. Hodges
 (Address) 3146 Main St.

15. FILED 6/20 27 M. M. Brown REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maple Hill Cemetery DATE OF BURIAL 6-21 1927

20. UNDERTAKER The Freeman Mortuary ADDRESS 3146 Main

