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

Do not use this space.

30080 Kerr

NOV 23 1927

1. PLACE OF DEATH

County Greene Registration District No. 318 File No.

Township Primary Registration District No. 2001 Registered No. 636

City Springfield (No. 813 So Missouri St. Ward)

2. FULL NAME Amanda A Lyman.

(a) Residence. No. 813 So Mo. St., Ward.
(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): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3/23/1847

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
80	6	21	

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) (STATE OR COUNTRY) Tenn.

PARENTS

10. NAME OF FATHER Wm. G. Patterson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn
12. MAIDEN NAME OF MOTHER Armentia Sessions
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

14. INFORMANT J. L. Lyman
(Address) Springfield Mo

15. FILED 10/18 1927 O C Horst MD REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1927, to Oct 14, 1927 that I last saw her alive on Oct 15, 1927, and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bright Disease

132H (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 129B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) U F Kerr, M.D.
Oct 16, 1927 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Dodson Cemetery
DATE OF BURIAL: 10/15 1927

20. UNDERTAKER: Alma Lohmeyer
ADDRESS: Springfield

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.