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

Do not use this space.

30464

File No. [illegible]

Registered No. [illegible]

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399

Township: Kans — Primary Registration District No.: 1002

City: Kansas City (No. 515 Ledg Bldg St. ..... Ward)

2. FULL NAME: Jane Lyon

(a) Residence. No. 1004 Locust 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 5 1908

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
19.	2	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Waitress

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) Inwood
(STATE OR COUNTRY) Iowa

PARENTS

10. NAME OF FATHER: C E Lyon

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

12. MAIDEN NAME OF MOTHER: Minnie Mitchell

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

14. INFORMANT: V E Lyon
(Address) Inwood, Iowa

15. FILED 10/21 1927 M. M. Crowe Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 19 1927

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental Chloroform Anaesthesia Poisoning (Vapor)
178A

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(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? yes

WHAT TEST CONFIRMED DIAGNOSIS? Gas Poisoning

10/21, 1927 (Signed) Alma Lombardi, M. D.
(Address) Deputy Coroner

*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: Inwood Iowa — DATE OF BURIAL: 10/21 1927

20. UNDERTAKER: The Taylor Funeral Home Inc — ADDRESS: .....

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.

AINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

equested to ... cated by check marks, lacking from the death cert...

Name: Jone Lyon

Who died at: Kansas City, Mo on Oct. 19, 1927.

Residence: No. _____ St. _____ (If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years ____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Accidental Chloroform Anesthesia Poisoning (Vapor)

Contributory: _____

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Where was disease contracted? _____

Did operation precede death? ~~yes~~ No Date of _____

... test confirmed diagnosis?

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