

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

1. PLACE OF DEATH

County St. Charles
Township
City St. Joseph (No. St. Joseph Hospital)

Registration District No. 757
Primary Registration District No. 3036

File No. 14528
Registered No. 67
St. _____ Ward _____

2. FULL NAME

Marie Lyons
(a) Residence. No. _____ St. _____ Ward. Postum des Dears Ins
(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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>James Lyons</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 14 - 1883</u>		
7. AGE	YEARS <u>44</u>	MONTHS <u>9</u>
	DAYS <u>16</u>	IF LESS than 1 day, _____ hrs. or _____ min.

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) Postage des Dears Ins
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Peter Mehnig

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

12. MAIDEN NAME OF MOTHER Mary Mehnig

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

14. INFORMANT Mrs. J. Lyons
(Address) Postage des Dears Ins

15. FILED 4/26/28 BY G. Bloebaum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 25 19 25
17. I HEREBY CERTIFY, That I attended deceased from _____, 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:
Myocardial degeneration (Chronic myocarditis)
122 B
930 (duration) 5 yrs. 6 mos. 6 ds.
CONTRIBUTORY (SECONDARY) Paralytic ileus
(duration) _____ yrs. _____ mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 4/25/28
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) B. K. Heubner M. D.
4/30, 19 28 (Address) St. Charles 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 St Francis Cemetery DATE OF BURIAL May 19 25

20. UNDERTAKER W. Hallenmyer + Sons 60 ADDRESS St Charles Mo

