

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

Do not use this space.

38412

19 1931

**1. PLACE OF DEATH**

County Adair Registration District No. 4  
 Township \_\_\_\_\_ Primary Registration District No. 3001  
 City Kirksville (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward \_\_\_\_\_)

File No. \_\_\_\_\_  
 Registered No. 181

**2. FULL NAME**

Demarrous Lyon  
 (a) Residence No. 7 Green St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 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 \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 27 1856  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
74 9 16

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer) Self  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Key

10. NAME OF FATHER Chas. Dewees  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Key  
 12. MAIDEN NAME OF MOTHER Jane Harris  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Key

14. INFORMANT Mrs. D. M. Frederick  
 (Address) 412 S. Haliburton

15. FILED 19/26 19 30 Mrs. C. H. Becker  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 13 1930  
 17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1930 to Dec 13, 1930 that I last saw her alive on Dec 13, 1930, and that death occurred, on the date stated above, at 1 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

cerebral hemorrhage  
87 B  
99 (duration) yrs. mos. ds. 3  
 CONTRIBUTORY (SECONDARY) Arterio Sclerosis  
 (duration) 70 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 Microscopical findings  
 (Signed) Ray M. Hoyle, M. D.  
 (Address) Kirksville 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 La Bell DATE OF BURIAL 12-15-1930

20. UNDERTAKER Davis Wilson ADDRESS Kirksville Mo

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.

