

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town 110 Mo.
(c) Name of hospital or institution:
Conly Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay in hospital or institution 7 days
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Clair
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME ELMER LYON

8. (b) If veteran, name war NO. 8. (c) Social Security No. NO.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Elizabeth Ann Keflogel 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased Oct. 14 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Louisy City MO.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Robert Lyons

13. Birthplace Ill
(City, town, or county) (State or foreign country)

14. Maiden name Anderson

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature R. F. Lyon

(b) Address Osceola MO.

17. (a) Burial (b) Date thereof 2-13-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Duncan MO.

18. (a) Signature of funeral director W. D. Crowe
(b) Address Osceola MO.
19. (a) Feb. 11, 1940 (b) Mr. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11
year 1940 hour 6 minute 15 P M.

21. I hereby certify that I attended the deceased from Feb. 4, 1940, to Feb 11, 1940;
that I last saw him alive on Feb 11, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial degeneration Duration 1 yr

Due to valvular lesion aortic stenosis 1 yr.
mitral insufficiency 1 yr.

Due to _____

Other conditions, Arteriosclerosis 9 yr
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury 2

23. Signature J. J. Lyon M.D. (M. D. or other)
Address 3620 Truitt Date signed 2/11-40
R. S. Crowe

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.