

AY 15 1940

399

Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
General Hospital #2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3-24-40-3-26-40
(Specify whether
 In this community 36 years
years, months or days)

3. (a) PRINT FULL NAME William Lyons 521

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 7 10 1877
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>8</u>	<u>16</u>	hr. _____ min.

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

10. Usual occupation unemployed

11. Industry or business _____

12. Name Unknown

18. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant's own signature Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 4-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Municipal Cem. Leeds, Mo.

18. (a) Signature of funeral director W. A. Lohmeyer

(b) Address A. Gen. Hosp. No. 1

19. (a) 4-22-1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 2416 Merington
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 26
 year 40 hour 5 minute 50 P. M.

21. I hereby certify that I attended the deceased from 3-24, 1940 to 3-26, 1940; that I last saw him alive on 3-26, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus with Coma

Due to 59

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 1

23. Signature [Signature] (M. D. or other) _____
 Address General Hospital #2 Date signed 3-27-

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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.