

NOV 12 1940

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Reeds Station, Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Kansas City Tuberculosis Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mos. 11 days  
(Specify whether)

In this community 10 years  
years, months or days

3. (a) PRINT FULL NAME Lyons, Emma

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lee, Hubert 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased March 3, 1910  
(Month) (Day) (Year)

8. AGE: Years 30 Months 7 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business 5

12. Name O. Malley, Peter

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

14. Maiden name Boyle, Bridget

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

16. (a) Informant K.C.M.T.B. Hospital

(b) Address Reeds Station, Kansas City

17. (a) Burial (b) Date thereof 10-9-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Willard W. Willey

(b) Address K.C. Mo

19. (a) Oct. 8, 1940 (b) M. M. Grove  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 3119 Euclid  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5 year 1940 hour 10 minute 55 a.m.

21. I hereby certify that I attended the deceased from June 24, 1940, to October 5, 1940 that I last saw her alive on October 5, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral pulmonary tuberculosis 10 yrs.

Due to Tbc.

Due to 23

Other conditions Broncho-pneumonia 4 yrs  
(Include pregnancy within 3 months of death)

Major findings: febrile, toxic myocarditis

Of operations \_\_\_\_\_

Of autopsy as above

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

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 \_\_\_\_\_

23. Signature W. C. 56 Hospital Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

*Handwritten notes and scribbles at the top of the page, including what appears to be a name and some illegible text.*

**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.....

working under my personal supervision.

Registered Apprentice No. 267

Signed H. M. H.

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, fact should be so stated above.**