

Registration District No. **209**

Primary Registration District No. **3043**

Registrar's No. **12**

**1. PLACE OF DEATH:**  
 (a) County Marion  
 (b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: ST Elizabeth Hosp.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 524 (Specify whether  
 In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MO (b) County Marion  
 (c) City or town Hannibal  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 306 S. 5th  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country 0

**3. (a) PRINT FULL NAME** Nellie Lyon  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Jan day 13  
 year 1943 hour \_\_\_\_\_ minute 12 M.

**4. Sex** Female **5. Color or race** White  
**6. (a) Single, widowed, married, divorced, single** Single  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if**  
 alive \_\_\_\_\_ years  
**7. Birth date of deceased:** Aug. 19, 1859  
(Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from** Jan 10 - 13  
 \_\_\_\_\_ 19 \_\_\_\_\_ to Jan 13 19 43  
 that I last saw her alive on Jan 13 19 43  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years 83 Months 4 Days 25 If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

**Immediate cause of death:** Cerebral Neuronology  
 Duration 4 days

**9. Birthplace** Cincinnati Ohio  
(City, town, or county) (State or foreign country)  
**10. Usual occupation** \_\_\_\_\_  
**11. Industry or business** \_\_\_\_\_

**Due to** \_\_\_\_\_  
**Due to** \_\_\_\_\_  
**Other conditions** \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**MOTHER FATHER**  
**12. Name** Patrick Lyons  
**13. Birthplace** Ireland  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Bridget Corbett  
**15. Birthplace** Ireland  
(City, town, or county) (State or foreign country)  
**16. (a) Informant** Wm Lyon  
**(b) Address** 306 S 5th Hannibal Mo  
**17. (a) Burial **(b) Date thereof** Jan 15 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** St Marys Cems  
**18. (a) Signature of funeral director** James Olanney  
**(b) Address** Hannibal Mo  
**19. (a) 1-16-43** **(b) R J Connor**  
(Date received local registrar) (Registrar's signature)**

**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?  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
**23. Signature** Wm Lyon (M. D. or other) \_\_\_\_\_  
**Address** Hannibal Mo Date signed Jan 16 43

**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

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

X28390  
4  
3

1146

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**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..... *Michael J. Hames* .....

Licensed Embalmer No. *3246*

P. O. Address..... *Hannibal Mo* .....

**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.**