

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 97

Primary Registration District No. 5353

Registrar's No. 12

**1. PLACE OF DEATH:**

(a) County Dallas

(b) City or town Red Fox Jackson

(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 2 years (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Dallas

(c) City or town Red Fox Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country Great 1

**3. (a) PRINT FULL NAME** JOSEPH P. LYONS

3. (b) If veteran, name war no

3. (c) Social Security No. 482-09-3428

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased June-6-1878  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>64</u>	<u>10</u>	<u>10</u>	hr. _____ min. _____

9. Birthplace Bohemia Bohemia 8  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Matthew Lyons

13. Birthplace Bohemia 8  
(City, town, or county) (State or foreign country)

14. Maiden name Anna Dra Losh

15. Birthplace Bohemia 8  
(City, town, or county) (State or foreign country)

16. (a) Informant Red Fox Mo

(b) Address Buffalo Mo

17. (a) Burial (b) Date thereof 4-20-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grattengely, Ill

18. (a) Signature of funeral director R. Jones

(b) Address Buffalo Mo

19. (a) June 8-1943 (b) ms Arthur Howe  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 16  
year 1943 hour 12 minute m. M.

21. I hereby certify that I attended the deceased from Feb. 5, 1943 to April 15, 1943  
that I last saw him alive on April 15, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage on April 10th 1943

Due to Essential Hypertension ?

Due to Generalized arteriosclerosis ?

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 J. J. Bennett, D.O. (M. D. or other) D.O.

Address Buffalo, Mo. Date signed 4/17/43

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

RECEIVED

District Health Officer No. 7,

District File Number 5-43590

Date Filed 6-23-43

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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 Clyde Montgomery

Licensed Embalmer No. 3582

P. O. Address Buffalo, 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.**