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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4966  
Registrar's No.

LED DEC 3 1943

Registration District No. 149 Primary Registration District No. 1002

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

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:  
2700 Tracy  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Clair 93

(c) City or town Osceola 2  
(If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Elizabeth M. Lyons

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 2 divorced

6. (b) Name of husband or wife L. Lyon 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 2 22 1884  
(Month) (Day) (Year)

8. AGE: Year 59 Months 9 Days 3 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace St Clair County Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name A. E. Replogle

13. Birthplace St Clair Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Ann E. Baker

15. Birthplace St Clair Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Dick Lyon

(b) Address Osceola Mo

17. (a) Burial (b) Date thereof 11-28-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Mo

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 25 year 1943 hour 1 minute 4 P. M.

21. I hereby certify that I attended the deceased from May 26 1943, to Nov 25 1943; that I last saw her alive on Nov 12 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral (apoplexy) hemorrhage

Due to Cerebral artery of Colon hyper-tension

Other conditions 462  
(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) No

(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 William L. Hunt (M.D. or other) \_\_\_\_\_ Address 612 May 12th Date signed 11-25-43

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

JAN 7 1944

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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 *J. B. Goodrich*.....

Licensed Embalmer No. *3038*.....

P. O. Address *Osceola 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.**