

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33281**
Registrar's No. **4190**

FILED OCT 29 1944 49

Registration District No. _____ 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:
5616 Olive
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community **20 years**
years, months or days)

3. (a) PRINT FULL NAME **JOHN J LYONS**
 3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widower**
 6. (b) Name of husband or wife **Catherine Lyons** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **About 1869**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75			hr. _____ min.

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

10. Usual occupation **Retired--15 years**

11. Industry or business **Machinist--Missouri-Pacific**

MOTHER FATHER

12. Name **Peter Lyons**
 13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
 14. Maiden name **No record**
 15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Catherine Lyons**
 (b) Address **5616 Olive**

17. (a) **Burial** (b) Date thereof **10/19/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Mary's Cemetery**

18. (a) Signature of funeral director **Swick & Tobin**
 (b) Address **20 West Linwood**

19. (a) **10-18-44** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson** **48**
 (c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. **5616 Olive** **8**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **16th** day **Oct**
 year **1944** hour **10.30** minute **P** M.

21. I hereby certify that I attended the deceased from **June 1942** to **Oct 16 1944**
 that I last saw him alive on **Oct 16 1944**
 and that death occurred on the date and hour stated above

Immediate cause of death **Myocarditis** Duration **10 yrs**
 Due to **Arterio Sclerosis** **10 yrs**

Due to **old age -**

Other conditions (Include pregnancy within 3 months of death)

C
 Major findings: _____
 Of operations _____ **93 d**
 Of autopsy _____
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?

23. Signature **W. S. Case** (Specify type of place) _____ (e) Means of injury **0**
 Address **4000 Bellvue St. E. 9/17/44**

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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.....

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.