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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 4 1945

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 3845

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

18
3
8

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:
5405 Forest /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 50 years
years, months or days

3. (a) PRINT FULL NAME MRS. ANNA LYONS

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife James E Lyons

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

7. Birth date of deceased about 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

about 69 hr. min.

9. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Michael Reidy

13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Bridget Welch

15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant James M Lyons

(b) Address 5405 Forest

17. (a) Burial (b) Date thereof 9/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Jurk & Robin Co

(b) Address 20 West Linwood

19. (a) 9-17-45 (b) Seraldine Holmes
(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. 5405 Forest 8
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 14th day Sept
year 1945 hour 3:45 minute P. M.

21. I hereby certify that I attended the deceased from 11th Sept
1945 to 14th Sept 1945
that I last saw her alive on Sept 14 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Senile with out cause
dementia ?

Due to _____

Due to _____

Other conditions Hypertension, created 10 yrs.
(Include pregnancy within 6 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 M. Harless M.D. (M. D. or other) _____

Address 6247 Brookside Date signed 15 Sept 1945

K.C. Ho.

1945

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,

 , Registered Apprentice No.
working under my personal supervision.

Signed

Charles M. Quirk

Licensed Embalmer No. 3774

P. O. Address

Kansas City 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.