S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

39470

State File No.

FILED DEC 21 1945

Registration District No. 318

Primary Registration District No. 1002

Registrar's No. 10651

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Saint Louis Maternity Hospital D
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1123a Palm
(If rural, give location)

(e) Citizen of foreign country? D (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME INFANT MALE LYONS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE D

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased November 30, 1945
(Month) (Day) (Year)

8. AGE: Years | Months | Days 4 | If less than one day 5¼ hr. min.

9. Birthplace St. Louis, Missouri D
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Thomas Joseph Lyons
13. Birthplace St. Louis, Missouri D
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lorraine Clara Russell
15. Birthplace St. Louis Missouri D
(City, town, or county) (State or foreign country)

16. (a) Informant Saint Louis Maternity Hosp
(b) Address 630 S. Kingshighway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Central Ind. C
(b) Address 1841 Carson

19. (a) DEC 8 1945 (Date received local registrar) (b) J. T. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 5
year 1945 hour 4:30 AM minute M.

21. I hereby certify that I attended the deceased from 12-7-45
~~12-5~~, 1945 to Dec 5, 1945
that I last saw him alive on Dec 5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death anencephaly,

Due to Congenital

Due to

Other conditions pseudohermaphroditism
(Include pregnancy within 3 months of death)
Dehydration

Major findings:
Of operations

Of autopsy

Duration 5 days (life)

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature H. H. Maxwell (M.D. or other)

Address 630 S Kingshighway Date signed 12-7-45

(Licensed Embalmer's Statement on Reverse Side)

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.

Not Embalmer

Signed John Stygar

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.