

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31220
Registrator's No. 8360

FILED OCT 9 1948

Registration District No. 318

Primary Registration District No. 1005

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 days
In this community Abt. 40 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4159 a Delmar
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank Lyons

3. (b) If veteran, name war Spanish-American 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased March 16th 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 6 6 hr. _____ min.

9. Birthplace Atlanta Georgia
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business ---

MOTHER FATHER
12. Name Branch Lyons
13. Birthplace unavailable
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ann (unknown)
(City, town, or county) (State or foreign country)
15. Birthplace unavailable
(City, town, or county) (State or foreign country)

16. (a) Informant Addie B. Redd
(b) Address 3904 Enright Ave.
17. (a) Burial (b) Date thereof 9/27/1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.

19. (a) SEP 24 1948 (b) J. F. Brudwick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 22
year 1948 hour 11 minute 30 p. M.

21. I hereby certify that I attended the deceased from Aug. 30 19 48 to Sept. 22 19 48
that I last saw him alive on Sept. 22 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage and Left Hemiplegia Duration Undet.

Due to _____
Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

None
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? _____

While at work? _____ (Specify type of place)
or Means of injury _____

23. Signature Ascar J. Davilla (M. D. or other) _____
Address 2601 N Whittier Date signed 9/24/48

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

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 John K. Cunningham
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.