S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 4 1948

Registration District No. 799

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 32981

Registrar's No. 4072

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: St. Joseph Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 DAYS (Specify whether

In this community 43 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 4312 Charlotte
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME James T. Lyndon

3. (b) If veteran, name war No

3. (c) Social Security No. 496-10-9771

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased October ~~12~~ 28, 1885
(Month) (Day) (Year)

8. AGE: Years 62 | Months 11 | Days 8 ~~24~~ | If less than one day hr. min.

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

10. Usual occupation Steamfitter

11. Industry or business U.S. Engineering Co.

FATHER
12. Name Thomas Lyndon
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Johanna Ahearn
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs James B. Thorpe
(b) Address 4312 Charlotte

17. (a) Burial (b) Date thereof Oct. 8, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Thos. E. Quirk
(b) Address 4316 Troost Ave.

19. (a) 10-7-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6th
year 1948 hour 3.15 P.M. minute M.

21. I hereby certify that I attended the deceased from Sept 1947, to Oct 6, 1948;
that I last saw him alive on Oct 6, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Cardiac failure	2 days
Due to Nephritis & Hepatitis from Cardiovascular	1 year
Due to disease	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings:
Of operations no 93
Of autopsy no

PHYSICIAN

Underline the cause of 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? John T. Skinner Means of injury

23. Signature John T. Skinner (M. D. or other) MD

Address 1102 Grand K. CMO Date signed 10-7-48

Jefferson City Printing Co.

(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.

Signed Thomas E. Lee

Licensed Embalmer No. 3775

P. O. Address A. C. Md

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.