FILED AUG 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26652

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 694

1. PLACE OF DEATH
a. COUNTY: GREENE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): So. Campbell Twp. Rural
c. LENGTH OF STAY (In this place): 8340
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Medical Center For Federal Prisoners

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Ohio
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Columbus
d. STREET ADDRESS (If rural, give location): unknown

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Paul
c. (Last): Lyons

4. DATE OF DEATH (Month) (Day) (Year): August 3, 1950

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Oct. 24, 1905
9. AGE (In years last birthday): 44 — IF UNDER 1 YEAR: Months 9, Days 17 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Various
11. BIRTHPLACE (State or foreign country): Lawrence County, Kentucky
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: (1st name unknown) Lyons
13b. MOTHER'S MAIDEN NAME: Maletia Ferguson
14. NAME OF HUSBAND OR WIFE: Bertha Powell (McDermott)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: File, MCFP, Springfield, Missouri

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage from left brain vessels. — INTERVAL BETWEEN ONSET AND DEATH: 1 day 6 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertensive vascular disease.
DUE TO (c) Hemiplegia, (right)/spinal paralysis. due to cerebra

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Absence of left kidney following operation. — 602x

19a. DATE OF OPERATION: 11-15-43
19b. MAJOR FINDINGS OF OPERATION: Pyelonephritis, chronic, secondary to nephrolithiasis & hydronephrosis. Papillary cystadenoma.
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): So. Campbell Twp. Greene Missouri
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* The Medical Staff June 24, 1950, *to* August 3, 1950, *that I last saw the deceased alive on* August 3, 1950, *and that death occurred at* 11:08a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. C. Rinck, M.D., Clinical Director
23b. ADDRESS: Medical Center For Federal Prisoners, Springfield, Mo.
23c. DATE SIGNED: 8-4-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 8/9/1950
24c. NAME OF CEMETERY OR CREMATORY: Unknown
24d. LOCATION (City, town, or county) (State): Columbus, Ohio

DATE REC'D BY LOCAL REG.: 8-11-50
REGISTRAR'S SIGNATURE: W E Handley M D
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Dunn-Ayre-Goodwin, Inc., Springfield, MO

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

....., Student Embalmer No. .....

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No. 4594

P. O. Address Springfield,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.