

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16641

XC 17 101 649  
R.# 108513  
FILED MAY 9 1953

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1219

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

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY ST. LOUIS  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE MISSOURI<br>b. COUNTY   |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN JEFFERSON BARRACKS, MO.   |   | c. CITY OR TOWN ST. LOUIS  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place)<br>75 DAYS  |   | e. STREET ADDRESS (If rural, give location)<br>3835A GREER AVENUE 2109   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.   |   |  |   |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) JOSEPH<br>b. (Middle) P.<br>c. (Last) LYONS  |   | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br>4-28-53  |   |
| 5. SEX<br>MALE  | 6. COLOR OR RACE<br>WHITE                   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>MARRIED  | 8. DATE OF BIRTH<br>3-8-97  |
| 9. AGE (In years last birthday)<br>56 yrs   | IF UNDER 1 YEAR<br>Months                   | IF UNDER 24 HRS.<br>Hours  | IF UNDER 12 HRS.<br>Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>FREIGHT SOLICITOR  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>RAILROAD  | 11. BIRTHPLACE (City and State or Foreign Country)<br>ST. LOUIS, MISSOURI   |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |  |   |
| 13a. FATHER'S NAME<br>PATRICK H. LYONS  |   | 13b. MOTHER'S MAIDEN NAME<br>KATHERINE CREEDEN   | 14. NAME OF HUSBAND OR WIFE<br>HELEN LYONS  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes, give war or dates of service)<br>WWI  |   | 16. SOCIAL SECURITY NO.<br>702 03 4373   | 17. INFORMANT'S SIGNATURE OR NAME<br>VA HOSPITAL RECORDS, JEFF. BKS, MO.  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |   | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF LEFT TONSIL WITH METASTASES<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><br>145X |   |
| 19a. DATE OF OPERATION<br>2-18-53   |   | 19b. MAJOR FINDINGS OF OPERATION<br>BIOPSY REVEALED METASTATIC LYMPH NODES   |   |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |   |
| 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)   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) (Sec)<br>VA   |   | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21f. HOW DID INJURY OCCUR?  |
| 22. I hereby certify that I attended the deceased from 12-12-53, 19__ to 4-28-53, 19__ and that death occurred at 8:30A M., from the causes and on the date stated above.   |   |  |   |
| 23a. SIGNATURE<br><i>[Signature]</i><br>J. P. KAMINSKAS, M.D.   |   | 23b. ADDRESS<br>VA HOSPITAL, JEFF. BKS, MO.  | 23c. DATE SIGNED<br>4-28-53   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   | 24b. DATE<br>4-30-1953                      | 24c. NAME OF CEMETERY OR CREMATORY<br>CALVARY  | 24d. LOCATION (City, town, or county) (State)<br>ST. LOUIS, MISSOURI  |
| DATE REC'D BY LOCAL REG.<br>4-30-53   | REGISTRAR'S SIGNATURE<br><i>[Signature]</i> | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS<br><i>[Signature]</i> 2849 No. Euclid Ave   |   |

**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..

Student.....  
Signature of Student Embalmer

Signed *Robert L. Brinkman*

Licensed Embalmer No. *355B*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.