

FILED MAY 12 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13752**
Registrar's No. **3983**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY OR TOWN ST. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN ST. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2204 Wyoming ST.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) a. (First) George		b. (Middle) M.		c. (Last) Lyons	
4. DATE OF DEATH (Month) (Day) (Year) May 1, 1954		5. STREET ADDRESS (If rural, give location) 2249 2204 Wyoming ST.			
6. SEX Male	7. COLOR OR RACE White	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	9. DATE OF BIRTH July 12, 1875	10. AGE (in years last birthday) 78	11. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Park Dept.		10b. KIND OF BUSINESS OR INDUSTRY CITY PARKS		11. BIRTHPLACE (City and State or Foreign Country) ST. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE Katie Lyons		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Edna J. Kerst 3810 California			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		19. MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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) 331X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **11:55A** m., from the causes and on the date stated above.

23a. SIGNATURE Arthur L. Taylor (Degree or title) 3	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 5.3.54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE May 4, 1954	24c. NAME OF CEMETERY OR CREMATORY New ST. Marcus	24d. LOCATION (City, town, or county) (State) ST. Louis, Co. Mo.
DATE REC'D BY LOCAL REG. MAY 3 1954	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walt Bur. L. & U.C. 2929 S. Jefferson	

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..

Student.....
Signature of Student Embalmer

Signed *J. M. Davis*.....

Licensed Embalmer No. *374*.....

P. O. Address *2929 1st St*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (If 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.