

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH.

34961

FILED NOV 15 1955

State File No.

9249

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lincoln | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI | | c. CITY OR TOWN Silex | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 05/1 |
| c. LENGTH OF STAY (In this place) | | e. STREET ADDRESS (If rural, give location) 05/1 | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL | | | |

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|--------------------------------------------------|------------|-------------|------------------------|-------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) ANNIE | a. (First) | b. (Middle) | c. (Last) LYONS | 4. DATE OF DEATH (Month) (Day) (Year) OCT. 24, 1955. |
|--------------------------------------------------|------------|-------------|------------------------|-------------------------------------------------------------|

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|----------------------|-------------------------------|-----------------------------------------------------------------------|---------------------------------------|-------------------------------------------|------------------------|------------------------|----------------------|
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Nov. 25, 1875 | 9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months | IF UNDER 24 Hrs. Hours | IF UNDER 1 Min. Min. |
|----------------------|-------------------------------|-----------------------------------------------------------------------|---------------------------------------|-------------------------------------------|------------------------|------------------------|----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10b. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (City and State or Foreign Country) Lincoln County, Mo. | 12. CITIZEN OF WHAT COUNTRY? U |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------|

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|-------------------------------------------|------------------------------------------------|-----------------------------------------------|
| 13a. FATHER'S NAME Benjamin Bowles | 13b. MOTHER'S MAIDEN NAME Sarah Worland | 14. NAME OF HUSBAND OR WIFE John Lyons |
|-------------------------------------------|------------------------------------------------|-----------------------------------------------|

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|--------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------|---------|
| 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 John Lyons, Silex, Mo. | ADDRESS |
|--------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------|---------|

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| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 12 hours |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration pneumonia | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral thrombosis DUE TO (c) congestive heart failure | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 332+ | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 21a. ACCIDENT (Specify) SUICIDE HOMICIDE | 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) m. | 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 **9-30**, 19 **55**, to **10-24**, 19 **55**, that I last saw the deceased alive on **10-24**, 19 **55**, and that death occurred at **12:30 a.m.**, from the causes and on the date stated above.

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|-------------------------------------------|-----------------------------|-----------------------------------------|-----------------------------------|
| 23a. SIGNATURE E Robert Schultz MD | (Degree or title) MD | 23b. ADDRESS 1515 LAFAYETTE AVE. | 23c. DATE SIGNED 10-24-55. |
|-------------------------------------------|-----------------------------|-----------------------------------------|-----------------------------------|

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|----------------------------------------------------------|---------------------------|------------------------------------|---------------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) removal | 24b. DATE 10-24-55 | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) EMI-Ilwood, Mo., Mo. |
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|--------------------------------------------------------------|--------------------------------------------|-----------------------------------------------------------------------|---------|
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 24 1955 | REGISTRAR'S SIGNATURE J. O. Mudd MD | 25. FUNERAL DIRECTOR'S SIGNATURE J.O. Mudd, Bowling Green, Mo. | ADDRESS |
|--------------------------------------------------------------|--------------------------------------------|-----------------------------------------------------------------------|---------|

(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..

Student.....
Signature of Student Embalmer

Signed *Ben C. Hoffmann*.....

Licensed Embalmer No.

P. O. Address *W. Hill*.....

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