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FILED JUN 14 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18962**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **531** Registrar's No. **1273**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Macoupin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City, Mo.	c. LENGTH OF STAY (in this place) 14 yr. 9mo	c. CITY OR TOWN Bunker Hill	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Christian Old People's Home		e. STREET ADDRESS (If rural, give location) Local 812th St	

3. NAME OF DECEASED (Type or Print) a. (First) Josie b. (Middle) _____ c. (Last) LeMay			4. DATE OF DEATH (Month) (Day) (Year) May, 22, 1956		
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH 2-25-63	9. AGE (In years last birthday) 93	IF UNDER 1 YEAR Months 2 Days 27	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Fosterburg, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Patrick Lyons		13b. MOTHER'S MAIDEN NAME Ella Lyons		14. NAME OF HUSBAND OR WIFE Cyrus LeMay	
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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 none		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Myrtle J. Sprague 6609 Washington			ADDRESS 6609 Washington
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18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ascending urinary infection 4-5 days			INTERVAL BETWEEN ONSET AND DEATH 4-5 days
		ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>			
		DUE TO (b) _____			
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> Avitaminosis, A.S. Heart Disease over 609 X Congestive Heart Failure 1 yr.			

19a. DATE OF OPERATION 5	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from **July 1, 1955**, to **May 22, 1956**, that I last saw the deceased alive on **May 22, 1956**, and that death occurred at **11:20P M.**, from the causes and on the date stated above.

23a. SIGNATURE Jan E. Holmes (Degree or title) M.D.		23b. ADDRESS 6600 Washington Univ City	23c. DATE SIGNED 5/23/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE May 26, 1956	24c. NAME OF CEMETERY OR CREMATORY Morrison Cemetery	24d. LOCATION (City, town, or county) (State) Bunker Hill, Illinois
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DATE REC'D BY LOCAL REG. 5-23-56	REGISTRAR'S SIGNATURE Herbert R. Dombke MD	25. FUNERAL DIRECTOR'S SIGNATURE Shepard Funeral Home, 1167 Hamilton Ave. ADDRESS	
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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.....
Licensed Embalmer No.....
P. O. Address.....

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.