

FILED NOV 1 1957

Registration District No. 149

Primary Registration District No. 1005

Registrar's No. 4764

300
1-57

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4016 GENESSEE ST			Length of stay in lb 90 YEARS	d. STREET ADDRESS (If outside, give location) 4016 GENESSEE ST		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELEANOR Middle ALEA Last LYONS				4. DATE OF DEATH Month OCT-14- Day 1957 Year			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 28 - 1867		9. AGE (In years last birthday) 90 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME			10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) KANSAS CITY MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME DENNIS DEVINE			13b. MOTHER'S MAIDEN NAME SARAH KENNEDY		14. NAME OF HUSBAND OR WIFE WILLIAM H. 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 Address MRS. JAMES L. KELLY 4016 GENESSEE ST. KANSAS CITY, MO.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure						INTERVAL BETWEEN ONSET AND DEATH about 1 mo.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) chronic pyelonephritis						unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility, Malnutrition						1000	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from 10/11/57 to 10/13/57 and last saw her alive on 10/13/57 Death occurred at 12:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) G. L. O'Connell M.D.			22b. ADDRESS 12714 So. 71 Huron Grandview, Mo.		22c. DATE SIGNED 10/14/57		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE OCT-16-1957	23c. NAME OF CEMETERY OR CREMATORY MT. ST. MARY'S CEMETERY		23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI		
24. FUNERAL DIRECTOR D.W. NEWCOMB'S SONS ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.			25. DATE RECD. BY LOCAL REG. 10-15-57		26. REGISTRAR'S SIGNATURE neva minshall		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diagnoses in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

G. L. O'Connell



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 *Chester K. Brown*

Licensed Embalmer No. *493*
P. O. Address *FEVH*

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.