

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042125

FILED VS NOV 17 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5456

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb. <u>Life</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5405 Forest</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>M.</u> Last <u>Lyons</u>	4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1960</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 1896</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>        </u> Days <u>        </u>	IF UNDER 24 HR Hours <u>        </u> Min. <u>        </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <u>Deputy Constable</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>County</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>James J. Lyons</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Reidy</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>        </u>	17. INFORMANT <u>James V. Horn - 5336 Forest</u> Address <u>5336 Forest</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion (acute)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>40 mins</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Thrombosis coronary artery</u>	
	DUE TO (c) <u>        </u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour <u>        </u> a.m. <u>        </u> p.m. <u>        </u> Month, Day, Year <u>        </u>
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 1-11-41 to 10-27-60 and last saw him alive on 10-27-60  
Death occurred at 9:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H. C. Ganley M.D.</u>	22b. ADDRESS <u>314 Angell Bldg</u>	22c. DATE SIGNED <u>10-28-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-29-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City, town, or county) (State) <u>K.C. Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Mellody-McGilley-Eylar, 20 W. Linwood K. C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-29-60</u>	26. REGISTRAR'S SIGNATURE <u>H. S. Dwyer</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert J. Gander

Licensed Embalmer No. 5103

P. O. Address H. C. M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.