MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-012017
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 726

FILED MAR 27 1961

DATE AMENDED

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RICHMOND HGTS. Length of stay in 1b YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Mary's Hospital Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY ST Louis
c. CITY OR TOWN Richmond Heights Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 7709 Lovella Avenue Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First MINNIE Middle CECELIA Last LYONS
4. DATE OF DEATH Month March Day 14, Year 1961
5. SEX female
6. COLOR OR RACE white
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 7/6/1876
9. AGE (last birthday) 84 IF UNDER 1 YEAR Months 8 Days 8 IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (City and state or country) Huntington, Indiana
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Charles Peter Richard
13b. MOTHER'S MAIDEN NAME Louisea Delphine Rhu
14. NAME OF HUSBAND OR WIFE Hyman S. Lyons
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
17. INFORMANT Address Marguerite Lyons, 7709 Lovella

INSTEAD OF

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH 2 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized Arteri-sclerosis
DUE TO (c) also Arteri-sclerotic Heart disease
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. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Sept. 1945, to Mar. 14 1961 and last saw her alive on 3-14-61
Death occurred at 8:45 p.m. 3-14-61 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE O.E. Williamson (Degree or title) M.D.
22b. ADDRESS 6336 Clayton Rd.
22c. DATE SIGNED 3/15/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Mar. 17, 1961
23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City, Kansas

24. FUNERAL DIRECTOR ADDRESS Ambruster Mortuary, 6633 Clayton Rd.
25. DATE RECD. BY LOCAL REG. 3-16-61
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4788

P. O. Address St Louis, Mo

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.