

Commonwealth of Kentucky  
 STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS  
**CERTIFICATE OF DEATH**

FORM V - 1908H 2-29-12  
 PLACE OF DEATH  
 County Carter  
 City Madison  
 Registration District No. 1388  
 Primary Registration District No. 7  
 File No. \_\_\_\_\_  
 Registered No. 9611  
 (If death occurred in a hospital or institution, give its name, instead of street and number.)

FULL NAME James A. Lyon

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**PERSONAL AND STATISTICAL PARTICULARS**

1 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
 (Write the word)

2 DATE OF BIRTH May 21, 1884  
 (Month) (Day) (Year)

3 AGE 24 yrs. 11 mos. 11 days  
 IF LESS than 1 day... hrs. or... min.?

6 OCCUPATION  
 (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business or establishment in which employed (or employer)

7 BIRTHPLACE (State or country) Elliot Co.

**PARENTS**

10 NAME OF FATHER Wesley Lyon  
 11 BIRTHPLACE OF FATHER (State or country) Virginia  
 12 M maiden name of MOTHER Spolly Wellman  
 13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_  
 (Address) \_\_\_\_\_

15 Filed April 27, 1918 by R. M. Craig REGISTRAR

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**MEDICAL CERTIFICATE OF DEATH**

14 DATE OF DEATH April 26, 1918  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended (occurred from April 26, 1918, to April 26, 1918) that I last saw him alive on April 26, 1918 and that death occurred on the date stated above at 4 P. M. The CAUSE OF DEATH was as follows:  
Heart failure with athero-sclerosis, hyperten-  
sion, chronic, and  
apoplexy.  
April 26, 1918. (Duration) 4 yrs. 11 mos. 11 ds.  
 Contributory (Secondary) \_\_\_\_\_  
 (Signed) Walter S. Howell, M. D.  
Apr. 27, 1918. (Address) \_\_\_\_\_

18 State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAIN HIRTS OR RECENT RESIDENTS)  
 At place of death... yrs... mos... ds. In the State... yrs... mos... ds.  
 Where was disease contracted, if not at place of death? \_\_\_\_\_  
 Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL March Cemetery DATE OF BURIAL April 27, 1918  
 20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

11-2114

WRITE PLAINLY, WITH UNFADING INK—THIS IS APPLICABLE TO ALL DEPARTMENTS RECORDS  
 N. B.—Every item of information should be correctly supplied. Ask churches, school teachers, neighbors, etc., for information. See instructions on back of certificate. Exact statement of OCCUPATION is very important.