LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

FEB 21 1929

486

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

15 0 0 1 1 2 1

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Camden

Township Auglaize
or
Village
or
City (NO. , St.; Ward)

Registration District No. 119 File No.

Primary Registration District No. 5170 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John David Lane

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Aug (Month) 2 (Day) 1864 (Year)

7 AGE 62 yrs. 4 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Camden Co Mo

PARENTS

10 NAME OF FATHER Samuel Hoston Lane

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky

12 MAIDEN NAME OF MOTHER Mary L Parish

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Camden Co Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Crall Sister
(Address) Montreal Mo

15 Filed Feb 8, 1929 Mrs W. J. Clarke Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 23 (Day) 1929 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 10, 1929, to Jan 23, 1929, that I last saw him alive on Jan 23, 1929, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia following Influenza
(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) W J Clarke M. D.
Jan 24, 1929 (Address) Montreal Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, 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 High Point Church

DATE OF BURIAL Jan 25, 1929

20 UNDERTAKER Frank Evans

ADDRESS Stoutland Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

6 DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7 AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191 ....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... , 191 .....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191 ....., to ....., 191 ....., that I last saw h..... alive on ....., 191 ....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... , 191 ..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, 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

DATE OF BURIAL

..... , 191 .....

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING