R 28 1930

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

Do not use this space.

5966

1. PLACE OF DEATH

County: Phelps — Registration District No. 677 — File No. —

Township: — Primary Registration District No. 4403 — Registered No. 9

City: Rolla (No. ..... St. ..... Ward)

2. FULL NAME Leonard W. Lane

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Elmeta Lane.

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 22, 1864

7. AGE: Years 65 | Months 7 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): /
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois

PARENTS

10. NAME OF FATHER: ✓
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Wm. Lane, Ill
12. MAIDEN NAME OF MOTHER: Sarah Flanagan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Illinois

14. INFORMANT: R. L. Lane
(Address): Sears California

15. FILED Feb 19 1930 Jos. F. Peters REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2-18-30

17. I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1930, to Feb. 18, 1930, that I last saw h— alive on 2-17-30, and that death occurred, on the date stated above, at 1:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Prostate

51C (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

1 DID AN OPERATION PRECEDE DEATH? yrs. DATE OF 1-29-30

WAS THERE AN AUTOPSY? —

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. Sidney McFarland M.D.

2-18, 1930 (Address) Rolla Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Hokewell Cem — DATE OF BURIAL: 2-20 1930

20. UNDERTAKER: Mill & Bicklider — ADDRESS: Rolla, Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

1. PLACE OF DEATH
County: Phelps — Registration District No. 677 — File No.
Township: — Primary Registration District No. 4403 — Registered No. 9
City: Rolla (No. , St. Ward)

2. FULL NAME: Leonard W. Lane
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTY)

PARENTS
10. NAME OF FATHER Wm Lane
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTY)

14. INFORMANT
(Address)

15. FILED April 17, 1930 Jos. F. Ayers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/18 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

5-5946