

APR 30 1930

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

Do not use this space.

9628

1. PLACE OF DEATH

County St. Louis
Township Anderson
City Ridgely

Registration District No. 55
Primary Registration District No. 4023

File No. _____
Registered No. 848
St. _____ Ward _____

2. FULL NAME Albert H. 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mary E. Lane</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 12-1889</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>60</u>	<u>11</u>	<u>3</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>Contractor</u>				
(b) General nature of industry, business, or establishment in which employed (or employer) _____				
(c) Name of employer _____				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 15 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 12th, 1930, to Mar 15th, 1930 that I last saw him alive on Mar 14th, 1930, and that death occurred, on the date stated above, at 9:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Traumatic Pneumonia
1:210M

(duration) _____ yrs. _____ mos. 4 ds.

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

9. BIRTHPLACE (CITY OR TOWN) Rolla Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER John Lane

11. BIRTHPLACE OF FATHER (CITY OR TOWN) England
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Nancy Reardon

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) England
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J. B. Stennett, M. D.
3-16-1930 (Address) Clarkton Mo

14. INFORMANT Mrs. Mary E. Lane
(Address) St Louis Mo. 5479 Claxton

*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 St Louis Mo DATE OF BURIAL _____ 19 _____

15. FILED 9-10-30 M. J. D. Mumma
REGISTRAR

20. UNDERTAKER W. K. Craig R. L. L. L. ADDRESS Malden

The accident occurred
at Gideon New Madrid
County Mo

ON BACK
OF SHEET

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County New Madrid Registration District No. 53 File No. 8
Township Gideon Primary Registration District No. 4033 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

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

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 _____ (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) yrs. mos. ds.
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED Apr 10 1930 M. M. Munn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/15 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw him alive _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Transverse
Thrombosis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) over
(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) OVER 217

*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

20. UNDERTAKER

ADDRESS

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

Drove car into ditch and
injured chest on wheel

5-9628
(1930)

5-9628
(41930)