NOV 3 1930

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

Do not use this space.

31842

1. PLACE OF DEATH
County Scott — Registration District No. 816 — File No. 1
Township — Primary Registration District No. 4492 — Registered No. 26
City Chaffee (No. ..... St. ..... Ward)

2. FULL NAME Mattie Jane Lane
(a) Residence. No. 423 Black St., 1 st Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 5 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)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 1st 1874

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	55	9	24	

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

9. BIRTHPLACE (CITY OR TOWN) Marco
(STATE OR COUNTRY) Indiana

PARENTS
10. NAME OF FATHER John Adams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't Know
(STATE OR COUNTRY) "
12. MAIDEN NAME OF MOTHER Sarah Girdley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bedford
(STATE OR COUNTRY) Indiana

14. INFORMANT A. B. Lane
(Address) Chaffee Mo

15. FILED 9-25, 1930 G. A. Sample REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 25 1930

17. I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Sept. 25, 1930 that I last saw her alive on 9-24, 1930, and that death occurred, on the date stated above, at 1:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis Pus Kidney. Gangrenous bed sores.
(duration) 1864 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Fracture R. femoral Neck
(duration) 1948 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 131
DID AN OPERATION PRECEDE DEATH Reduction of Fracture
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
(Signed) G. A. Sample M. D.
9-25, 1930 (Address) Chaffee 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 Lernier Cem. Cape Girardeau — DATE OF BURIAL 9/26 1930

20. UNDERTAKER H F Stubb — ADDRESS Chaffee Mo

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.

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: Scott — Registration District No.: 816 — File No.:
Township: — Primary Registration District No.: 4492 — Registered No.:
City: Chaffee (No. ; St. Ward)

2. FULL NAME: Mattie Jane 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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

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, professing, 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 COUNTRY)

PARENTS
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 Sept 25 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 25 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:
Chronic Interstitial Nephritis - Pus Kidney
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Fracture Rt. Femurd neck (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Visiting a neighbor and as she started home, accidentally fell from the neighbor's porch.
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

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N. B. item of information should be careful supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE DEATH in plain terms, so that it may 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

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