

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

Do not use this space.

36065

1. PLACE OF DEATH

County Jackson
 Township Kan
 City Kansas City (No. Kansas City General Hospital)

Registration District No. 399
 Primary Registration District No. 1002

File No. _____
 Registered No. 4466 Ward _____

2. FULL NAME

Lane, Edward

(a) Residence, No. 1330 Harrison St. Ward. 2
 (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>Nellie Lane</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>3-1-1888</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>42</u>	<u>8</u>	<u>1</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>Iron worker</u>				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				

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

PARENTS	10. NAME OF FATHER <u>sent know</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>sent know</u>
	12. MAIDEN NAME OF MOTHER <u>sent know</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>sent know</u>

14. INFORMANT Recus Sabat
 (Address) Kansas City General Hospital

15. FILED 11/4 30 M. M. Lawrence
 REGISTRAR Ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-2-1930

17. I HEREBY CERTIFY, That I attended deceased from 10-31-1930, to 11-2-1930, that I last saw him alive on 11-2-1930, and that death occurred, on the date stated above, at 1:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage from duodenal ulcer
1170
12573

CONTRIBUTORY (SECONDARY) 111B2
 (duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED (POSTMORTEM)?
 (Signed) P. E. Williams M. D.
11-2-1930 (Address) Dept. K. B. Gen. Hosp.

*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 Rx. Maple Cemetery DATE OF BURIAL 11-5-30

20. UNDERTAKER O. J. Mack ADDRESS 1915 E. 15

