

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

Do not use this space.

MAY 25 1931

1. PLACE OF DEATH

County Boston
Township
City Jasper (No. _____) St. _____ Ward _____

Registration District No. 410
Primary Registration District No. 4243

File No. 11569
Registered No. 13

2. FULL NAME William Schuyler - Lane

(a) Residence, No. Jasper, Mo. St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 2 1879

7. AGE YEARS MONTHS DAY If LESS than 1 day, hrs. or min.
59 11 23

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Irving, Ill.

FATHER 13. NAME R. P. Lane

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jerseyville, Ill.

MOTHER 15. MAIDEN NAME Emmy Underhill

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rochester, New York

17. INFORMANT (ADDRESS) Wm. G. Lane, Jasper, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mitchell Cemetery DATE April 27, 1931

19. UNDERTAKER (ADDRESS) Kree Mortuary, Carthage, Mo.

20. FILED 4-27, 1931 J. A. Adams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 25, 1931

22. I HEREBY CERTIFY, That I attended deceased from 4/28, 1931, to 4/25, 1931
I last saw him alive on 4/23, 1931 Death is said to have occurred on the date stated above, at 12:20 P.M.
The principal cause of death and related causes of importance were as follows:

Tuberculosis -
23A
Other contributory causes of importance:
Date of onset

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) W. H. Hendricks, M. D.
(Address) Jasper, Mo.

The following information was obtained from the records of the State of Maine, Department of Health and Human Services, regarding the activities of the Maine State Planning Board during the year 1964.

The Maine State Planning Board was organized on July 1, 1963, pursuant to the provisions of Chapter 10, Section 101 of the Maine Revised Statutes. The Board is composed of representatives from various state agencies and departments, and is charged with the responsibility of coordinating and planning the state's economic and social development.

During the year 1964, the Board has held several public hearings and has received numerous suggestions and recommendations from citizens and organizations throughout the state. The Board has also conducted extensive research and analysis into the state's economic and social conditions, and has prepared a comprehensive report on the state's development needs.

The Board's report, which was submitted to the Governor in December, 1964, contains a detailed analysis of the state's economic and social conditions, and a series of recommendations for the improvement of the state's development. The Board's report is a valuable resource for the state's planning and development efforts.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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.

1. PLACE OF DEATH.
 County Casper Registration District No. 410 File No. _____
 Township _____ Primary Registration District No. 4243 Registered No. 15-
 City Casper (No. _____) St. _____ Ward _____

2. FULL NAME William Schuyler 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 (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 2 1891

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>59</u>	<u>11</u>	<u>23</u>		

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 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 4-27-31 D.A. Holmes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 25 1931

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of Lungs
 (duration) _____ yrs. _____ mos. _____ ds.

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

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) V.H. Hendricks, M. D.
 _____, 19____ (Address) Casper 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 _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

S-14569