

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.

OCT 18 1934

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

Do not use this space.

34955

1. PLACE OF DEATH

County Stoddard
Township ELK
City (No. _____) _____ St. _____ Ward _____

Registration District No. 836
Primary Registration District No. 6100

File No. 69
Registered No. 69

2. FULL NAME Jerome B 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>Emma Lane</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>1867-10-22</u>				
7. AGE	YEARS <u>67</u>	MONTHS <u>6</u>	DAYS <u>28</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farming</u>			
	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.	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>			
	13. NAME <u>Charles Lane</u>			
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill</u>			
	15. MAIDEN NAME <u>Lucinda Sather</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>N.C.</u>				
17. INFORMANT <u>Emma Lane</u> (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Matthews</u> DATE <u>9-21-34</u>				
19. UNDERTAKER <u>T. C. Knight</u> (ADDRESS) <u>Parma mo</u>				
20. FILED <u>1071</u> 19 <u>34</u> <u>Wilma Allen</u> Registrar.				

✓ MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept-20-1934

22. I HEREBY CERTIFY, That I attended deceased from May 18, 1934, to May 20, 1934
I last saw him alive on May 18, 1934. Death is said to have occurred on the date stated above, at 3:30 p.m.

The principal cause of death and related causes of importance were as follows:

Chronic Bright's Disease Date of onset 131

Other contributory causes of importance:
Stroke of Paralysis 1930

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) Dr. John Beat, M. D.

(Address) Parma - Mo

