

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**

Do not use this space.

SEP 29 1936

30923

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
 Township Kaw Primary Registration District No. \_\_\_\_\_  
 City Kansas City (No. 633 West 70th) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 3721

**2. FULL NAME**

Wade Lane Laning

(a) Residence, No. 633 West 70th 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sallie Laning

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 28, 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
68 4 12

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired  
 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) Kentucky

MOTHER FATHER 13. NAME Theodore P. Laning

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

15. MAIDEN NAME Emma Lane

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT Mrs. Sallie Laning (ADDRESS) 633 West 70th

18. BURIAL, CREMATION, OR REMOVAL Belair Hills Cemetery 8/13

19. UNDERTAKER Stine & McClure (ADDRESS) 3235 Gillham Plaza

20. FILED 8/12, 1936 M. M. Crowe, M.D. Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 10, 1935

22. I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_, 19\_\_\_\_

I last saw him/her live on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Sunshot around of the head

Other contributory causes of importance: 167

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis \_\_\_\_\_ as there an autopsy? \_\_\_\_\_

23. If death was due to external cause (violence), fill in the following: Accident, suicide, or homicide. Date of injury \_\_\_\_\_  
 Where did injury occur 633 West 70th St (Specify city or town, county, and state)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Primary firearm  
 Nature of injury \_\_\_\_\_

24. Was disease or injury related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_ M. D.  
 (Address) \_\_\_\_\_

