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.

REC'D AUG 18 1939

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

26605
Do not use this space.

1. PLACE OF DEATH
(a) County RALLS
(b) Township CENTER
(c) City CENTER
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 20 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 4431
Primary Registration District No. 725
Registered No. .....

2. PRINT FULL NAME SARAH ELIZABETH LANE
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
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 HENRY LANE

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-28-1853

7. AGE: Years 85 | Months 9 | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSE WIFE
9. Industry or business in which work was done, as saw mill, bank, etc. HOME
10. Date deceased last worked at this occupation (month and year) 1938
11. Total time (years) spent in this occupation LIFE

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) RALLS CO MO

FATHER
13. NAME JAMES GREGORY
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

MOTHER
15. MAIDEN NAME AMANDA CRAWFORD
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

17. INFORMANT MRS. E. A KEITHLY
(ADDRESS) CENTER MO

18. BURIAL, CREMATION, OR REMOVAL
PLACE UNION CHAPEL DATE JULY 2 39

19. FUNERAL DIRECTOR (NAME) COUCH-HULSE
(ADDRESS) CENTER MO

20. FILED 8/5 1939 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JUNE 29 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan. 16 1939, to June 29 1939
I last saw him alive on June 29 1939. Death is said to have occurred on the date stated above, at 5:10 P
The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis (chronic)	I/16/39

Other contributory causes of importance: 93C

Unknown

Name of operation ..... Date of .....
What test confirmed diagnosis? Phys. Exam Was there an autopsy? no

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? no
If so, specify .....
(Signed) C. H. Brooks, M. D.
(Address) Center, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 889-1490
Date Filed AUG 15 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, [signature], or by .....

Registered Apprentice No. ....., working under my personal supervision.

Signed [signature]

Licensed Embalmer No. 3356

P. O. Address Center Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.