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

OCT 9 1939

2

33700
Do not use this space.

1. PLACE OF DEATH
(a) County Stoddard
(b) Township Pike
or
(c) City Bell City
Registration District No. 834
Primary Registration District No. 6077
Registered No.
(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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 500 William Lane
(a) Residence, No. Bell City, Missouri R.R. 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: None
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): January 9, 1866
7. AGE: Years 73, Months 7, Days 25; If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Retired
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): Scott County, Missouri 0

FATHER
13. NAME: James Lane 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown 9

MOTHER
15. MAIDEN NAME: Theresa Cooper
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Mrs. Thomas Myers, Sikeston, Missouri
18. BURIAL, ~~CREMATION OR REMOVAL~~
PLACE Carpenter Cemetary McMullin Mo DATE September 5, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): H. J. Welsh, Sikeston, Mo
20. FILED ....., 19.....
Local Registrar 175

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): September 4, 1939
22. I HEREBY CERTIFY, That I attended deceased from Sept 4, 1939, to Sept 4, 1939
I last saw him alive on Sept 4, 1939. Death is said to have occurred on the date stated above, at 6:00P m.
The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia — Date of onset Sept 1 39
108
Other contributory causes of importance:
Generalized Arteriosclerosis, Chr. Myocarditis
Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical 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) Howard M Fendrick, M. D.
(Address) Sikeston Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2
District File Number 039-243
Date Filed 6-5

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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

3370

Do not use this space.

1. PLACE OF DEATH
   (a) County Stoddard — Registration District No. 834
   (b) Township Pike — Primary Registration District No. 6097 — Registered No.
   (c) City — (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William 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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): S

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

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

7. AGE: YEARS 73 — MONTHS 7 — DAYS 25 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

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

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE — 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 11/16, 1939 D S McGee Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 4, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19....
I last saw h..... alive 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:

	Date of onset

Other contributory causes of importance:

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) Howard M. Kendig M.D.
(Address) Sikeston Mo

SUPPLEMENTARY

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 COMPLETED AS PRESCRIBED BY LAW.