

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

*Brown*  
**22571**  
 Do not use this space.

1. PLACE OF DEATH **15 1940** **2**  
 (a) County Polk Registration District No. 701  
 (b) Township Chiquist **0** Primary Registration District No. 6292 Registered No. 24  
 (c) City Chiquist or Chiquist (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 George W. Lane  
 (a) Residence, No. P.O. Box St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**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>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>March 1, 1854</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>March 1 - 1854</u>		
7. AGE	YEARS <u>85</u>	MONTHS <u>2</u>
	DAY <u>19</u>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>farmer</u>	11. Total time (years) spent in this occupation <u>life</u>
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>farmer</u>	
	10. Date deceased last worked at this occupation (month and year) _____	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u> <span style="float: right;"><b>0</b></span>		
FATHER	13. NAME <u>George Lane</u> <span style="float: right;"><b>9</b></span>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u> <span style="float: right;"><b>9</b></span>	
MOTHER	15. MAIDEN NAME <u>Lizzie Halcome</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>	
17. INFORMANT <u>Daniel Lane</u> (ADDRESS) <u>Polk Co. Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Chiquist</u> DATE <u>May 21, 1940</u>		
19. FUNERAL DIRECTOR (NAME) <u>Hutchinson &amp; Co.</u> (ADDRESS) <u>Polk Co. Missouri</u>		
20. FILED <u>5-21-40</u> 19 <u>40</u> <u>J. R. Roberts</u> Local Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 20, 1940

22. I HEREBY CERTIFY, That I attended deceased from May 17 1940 to May 20 1940  
 I last saw him alive on May 17 1940. Death is said to have occurred on the date stated above, at 9:45 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Arteriosclerotic (right) ✓  
and other - unknown

Other contributory causes of importance:  
Coronary hypertension  
and other - unknown ✓

Name of operation None 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? NO 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 None  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) Chas. J. Brown M. D.  
 (Address) Polk Co. Mo.

Date of onset  
1869  
1870  
1840

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.

572

RECEIVED  
District Health Officer No. 7,  
#68  
#48-9  
#7-1-9  
District Health Officer No. 7,  
#68  
#48-9  
#7-1-9

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 comply with the above constitutes grounds for revocation of license.)

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **22571**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **701**

Primary Registration District No. **6292**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Polk**  
(b) City or town **Clargent**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME **Geo W. Lane**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years  
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **75-** Months **2** Days **19** If less than one year \_\_\_\_\_ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **2** year **1970** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death **Hemiplegia (right) and cerebral hemorrhage**

Due to **Cerebral hemorrhage**

Due to \_\_\_\_\_

Other conditions **Hypertension and arteriosclerosis** (Include pregnancy within 6 months of death)

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? (Specify type of place) (a) Means of injury \_\_\_\_\_

23. Signature **Chas H Brown** (Date received local registrar) (b) (Registrar's signature) **Fairplay** Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

