

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **24126**
2736
 Registrar's No. _____

Registration District No. **399**

Primary Registration District No. **1002**

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.

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas city
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: General Hospital # 2 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community Unknown
 years, months or days

3. (a) PRINT FULL NAME Claude Lane
 (b) If veteran, name war No
 (c) Social Security No. 100

4. Sex male
 5. Color or race color
 6. (a) Single, widowed, married, divorced divorced
 6. (b) Name of husband or wife Unknown
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Unknown
 (Month) (Day) (Year)

8. AGE: 48 Years
 Months _____ Days _____
 If less than one day _____ hr. _____ min.

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

10. Usual occupation House work

11. Industry or business Artist

MOTHER FATHER { 12. Name Jerril Lane 9
 13. Birthplace Jefferson Texas
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Adella Moss
 (b) Address 2432 Forest

17. (a) burial (b) Date thereof 7-8-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Boyle
 (b) Address 1708 Tracy

19. (a) July 8, 1940 (b) M. M. Crowe
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2432 Forest
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 2 - 40
 year _____ hour _____ minute 27 M.

21. I hereby certify that I attended the deceased from _____, 19____;
 that he/she was alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pulmonary Edema
 Duration _____

Due to Arterio Sclerosis 96'
Arterio Sclerosis

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____
 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? _____

(Specify type of place) _____
 While at work _____ (e) Means of injury _____
 23. Signature Russell (M. D. or other) _____
 Address Forest Date signed _____

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 *[Handwritten Signature]*
Licensed Embalmer No. 3388
P. O. Address K.C. MO

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.