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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30942**
Registrar's No. **3505**

Registration District No. 399

Primary Registration District No. 1002

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

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:
St. Joseph
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether

In this community 7 yrs
years, months or days)

3. (a) PRINT FULL NAME MARJORIE LANE

3. (b) If veteran, name war No

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jack Lane

6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased August 24 1909
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

31 0 12 hr. 1 min.

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

10. Usual occupation House wife

11. Industry or business 1

12. Name John Arvid Johnson

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

14. Maiden name Emelia Olson

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

16. (a) Informant H.J. Lane

(b) Address 914 Strode Independence Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/40
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn, K. C. Mo.

19. (a) Sept. 7, 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 Independence
(If outside city or town limits, write "RURAL")

(d) Street No. 914 Strode
(If rural, give location)

(e) If foreign born, how long in U. S. A.?.....years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6th year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Sept 3, 1940, to Sept 16, 1940;
that I last saw her alive on Sept 15, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death acute myocarditis 3 days

Due to Bronchopneumonia 2 wks.

Due to _____

Other conditions 1077
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration

PHYSICIAN 107

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) (e) Means of injury 1

23. Signature A. J. O'Leary M.D. (M. D. or other)

Address 10307 Independence Ave Date signed 9/6/40
S.E. Mo

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

Denzil P. Browning

Licensed Embalmer No. *2724*

P. O. Address. *H. C. No*

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, fact should be so stated above.