DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 42740

JAN 25 1941

Registration District No. 398 — Primary Registration District No. 3019 — Registrar's No. 310

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

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Independence (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Independence Sanitarium (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community 17 years 1.

**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. 101 So. Pleasant St. (If rural, give location)

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

**3. (a) PRINT FULL NAME** Emma M Lane

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex F 5. Color or race Wht 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Joshua Lane 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Aug (Month) 26 (Day) 1847 (Year)

8. AGE: Years 93 Months 3 Days 17 If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business Retired

FATHER
12. Name Joseph Younger
13. Birthplace Chatham N.C. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Susannah McCurley
15. Birthplace Allen Co. Ky (City, town, or county) (State or foreign country)

16. (a) Informant Harold G Lane

(b) Address R2 - Dickinson Road

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mandeville Grove

18. (a) Signature of funeral director Cato & Speaks

(b) Address Independence Mo.

19. (a) Dec. 14, 1940 (Date received local registrar) (b) F. L. Cook M.D. (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 13 year 1940 hour 10:00 minute A.M.

21. I hereby certify that I attended the deceased from Dec seven, 1940, to Dec. thirteen, 1940 that I last saw her alive on Dec. thirteen, 1940 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Bilateral Lower Lobar Pneumonia | 3 d |
| Due to: Fracture rt hip - intertrochanteric | 6 d |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): Arteriosclerosis | ? |

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? 360 (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature Chas. T. Grabbe (M. D. or other)

Address Independence Mo Date signed 12/14/40

(Licensed Embalmer's Statement on Reverse Side)

144 B
94

**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 me

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

working under my personal supervision.

Signed Roland R. Speaks

Licensed Embalmer No. 3604

P. O. Address Independence

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

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

o. 2B
21-40
X22659

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# STANDARD CERTIFICATE OF DEATH

State File No. 42740

Registration District No. 398 Primary Registration District No. 3019 Registrar's No.

SUPPLEMENTARY

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Independence (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)

**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.

3. (a) PRINT FULL NAME Emma M. Lane

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 93 Months 3 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 13 year 1940 hour minute M.

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

Immediate cause of death Bilateral Lower Lobar Pneumonia

Due to Fract rt hip

Due to

Other conditions Arterio Sclerosis Generalized (Include pregnancy within 3 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) Accident

(b) Date of occurrence 12/10/40

(c) Where did injury occur? Independence (City or town) Jackson (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)

While at work? Yes (e) Means of injury fall

23. Signature Chas F Granke (M. D. or other) MD

Address Independence Mo Date signed 2/10/41