

FILED OCT 14 1941

Registration District No. **318**

Primary Registration District No. **5440**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield Rural Camp**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Ozark Osteopathic Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
(Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME **Henry Clay Lane**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Lizzy Lane** 6. (c) Age of husband or wife if alive **Unknown** years
7. Birth date of deceased **December 21 - 1874**
(Month) (Day) (Year)

8. AGE: Years **166** Months **8** Days **15** If less than one day hr. min.

9. Birthplace **Webster Co., Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business **Farm**

MOTHER FATHER { 12. Name **William Lane**
13. Birthplace **Unknown Tennessee**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown Tennessee**
(City, town, or county) (State or foreign country)

16. (a) Informant **Clay William Lane**
(b) Address **Eldon, Mo.**

17. (a) **Marshfield** (b) Date thereof **9-8-41**
(Burial, ~~cremation~~) (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ **Marshfield**

18. (a) Signature of funeral director **Rev. Rainey**
(b) Address **Marshfield, Missouri**

19. (a) **9-8-41** (b) **W.E. Handley, MD**
(Date received local registrar) (Registrar's signature) **WJK**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Webster 112**
(c) City or town **Marshfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **Unknown**
(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 **1941** hour **11** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **August 14**, 1941, to **Sept. 6**, 1941;
that I last saw him alive on **Sept. 6** and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia**

Due to **Enlarged Prostate**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) Means of injury **22**

23. Signature **William Lane** or other) **WJK**
Address **2100 S. Holland St. Marshfield** Date signed **9-6-41**

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

0090

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. 3312

P. O. Address Marshfield, Ma

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 91543
Registrar's No.

Registration District No. 318

Primary Registration District No. 5440

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural
(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.
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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Jerry C. 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 m

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

7. Birth date of deceased Dec 21, 1874
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 5 (If less than one day 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)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 11-22-41 (b) W. E. Haudley, M.D.
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....

that I last saw him..... live on..... 19.....

and that death occurred on the date and hour stated above.

Immediate cause of death uremia, caused by hyperkalemia from

Due to enlarge prostate

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

13212

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.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-31543 1941