

BUREAU OF THE CENSUS  
FILED NOV 19 1941

Registration District No. **104**

Primary Registration District No. **3008**

Registrar's No. **271**

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

1. PLACE OF DEATH: **Calloway**

(a) County **Fulton P.T.**

(b) City or town **Fulton P.T.**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **State Hospital #112**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **43 yrs 8 mos**  
(Specify whether In this community years, months or days) **11 days**

3. (a) PRINT FULL NAME **FRANK LANE**

3. (b) If Veteran, name war **D.K.**

3. (c) Social Security No. **none**

4. Sex **male D**

5. Color or race **white**

6. (a) Single, married, divorced, **single**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **18703** years

7. Birth date of deceased **D.K.** (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>68</b>	<b>O.K.</b>	<b>PK</b>	hr. min.

9. Birthplace **D.K.** (City, town, or county) **4** (State or foreign country)

10. Usual occupation **D.K.**

11. Industry or business

MOTHER FATHER { 12. Name **D.K.** **4**

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

14. Maiden name **D.K.** **4**

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

16. (a) Informant **Hospital Records**

(b) Address **State Hospital - Fulton, Mo.**

17. (a) **Burial** (Burial, cremation, or otherwise) (b) Date thereof **68 10-1941** (Month) (Day) (Year)

(c) Place: burial or cremation **Hospital grounds**

18. (a) Signature of funeral director **G. B. Thomas**

(b) Address **302 Market St. Fulton, Mo.**

19. (a) **Oct 10, 1941** (Date received local registrar) (b) **R. N. Creiss** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson 14**

(c) City or town **D.K.** (If outside city or town limits, write "RURAL") **1**

(d) Street No. **20** (If rural, give location) **0**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **8** year **1941** hour **1** minute **30** A. M.

21. I hereby certify that I attended the deceased from **April 5**, 1941, to **Oct 8**, 1941; that I last saw him alive on **Oct 7**, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **10 hrs**

Due to **Hypertension** **3**

**arteriosclerosis** **3**

Due to **1318**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Massive Cerebral Hemorrhage**

Of operation: **Cardiac Hypertrophy**

Of autopsy: **arteriosclerosis**

**Chronic nephritis**

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) (e) Means of injury **7**

23. Signature **Katherine Shirley Brown** (M. D. or other) **M.D.**

Address **State Hospital, Fulton** Date signed **10-8-41**

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**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, fact should be so stated above.**