

S. No. 2
OM-5-42
Ev. 5-17-39
X32873

26433

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 11 1942

Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 3264

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: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community 40 years,

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. 809 Lydia
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Mrs. Tina Lane

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 30th
year 1942 hour 9 minute 40 A.M.

4. Sex Female / 5. Color or race white

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

6. (b) Name of husband or wife William W. Lane,

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased June 7 1880
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-29-42 19..... to 8-30-42 19.....; that I last saw h. er alive on 8-30-42 19.....; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>2</u>	<u>23</u>hr.min.

IMMEDIATE CAUSE OF DEATH
**BRONCHOPNEUMONIA; HYPERTHYROIDISM;
ACUTE CIRCULATORY FAILURE**

Due to 63 B

Other conditions See above
(include pregnancy within 3 months of death)

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

10. Usual occupation Housewife,

11. Industry or business X

Major findings:
Of operations.....
Of autopsy.....
See above

MOTHER FATHER

12. Name Riley Coach,

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

14. Maiden name Martha Odell,

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

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).....
Indef. mo. R.R.

(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 Dwight R. Thurman (M.D. or other).....
Address Med. Dir. K.C. Gen. Hospital K.C. Mo. Date signed.....

16. (a) Informant William W. Lane,

(b) Address 809 Lydia, Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-42
(Month) (Day) (Year)

(c) Place: burial or cremation at Salem Church Cemetery,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 9-1-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

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

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

Leon H. Stewart

Licensed Embalmer No. *4177*

P. O. Address *Hannas City, 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, fact should be so stated above.