

FILE MAR 5 1943

Registration District No. 179

Primary Registration District No. 1002

Registrar's No. 814

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. Gen. Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community 26 years (Specify whether
years, months or days)

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. 738 No. Prospect (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Ollie Daniels Lane

3. (b) If veteran, name war

no

3. (c) Social Security No. 496-JI-0544

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Paul C. Lane

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

7. Birth date of deceased April 9 1915
(Month) (Day) (Year)

8. AGE:

27 Years

10 Months

6 Days

If less than one day

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

10. Usual occupation Baker Lockwood Machine

11. Industry or business

MOTHER { 12. Name Oscar M. Daniels

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

14. Maiden name Mable G. Mon

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

16. (a) Informant Paul C. Lane

(b) Address 738 North Prospect

17. (a) Burial (b) Date thereof Feb. 18-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

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

(b) Address 918 Brooklyn

19. (a) 2-16-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15th
year 1943 hour 5 minute 45 A. M.

21. I hereby certify that I attended the deceased from 2-14-43, 19, to 2-15-43, 19, that I last saw him alive on 2-15-43, 19, and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia - not confirmed

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

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 Amey R. Johnson (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

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.