

**FILED MAR 25 1943**

Registration District No. 149

Primary Registration District No. 1002

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

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:  
3550 Wyoming  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 40 years years, months or days)

3. (a) PRINT FULL NAME Mr. Robert A. Lane

3. (b) If veteran, name war No 3. (c) Social Security No. 494-12-6667

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emma Lane 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased July 3 1894  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>8</u>	<u>14</u>	hr. min.

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

10. Usual occupation Hoisting Engineer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John D. Lane

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

14. Maiden name Mary A. Tull

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

16. (a) Informant Mrs. Emma Lane

(b) Address 3550 Wyoming

17. (a) Burial (b) Date thereof 3-19-1943  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cemetery

18. (a) Signature of funeral director Freeman Mortuary  
 (b) Address Kansas City, Mo.

19. (a) 3-18-43 (b) M. M. Cromel  
 (Date received local registrar) (Registrar's signature)

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. 3550 Wyoming  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 17  
 year 1943 hour 7:15 minute am

21. I hereby certify that I attended the deceased from May 16 1943 to Mar 17 1943  
 that I last saw him alive on Dec 23 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death auricular peritonitis 4/5

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

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? Home  
 (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 Louis Swain (M. D. or other) \_\_\_\_\_  
 Address 820 Popple St Date signed 3/17/43

11/21/57  
Clarence W. Charles

**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 Clarence W. Charles  
Licensed Embalmer No. 3473  
P. O. Address 76 E 7th

**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.