

FILED MAY 3 1945

318

Primary Registration District No.

1003

11700

3638

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Luke's Hospital *0*
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Mos. (Specify whether)
 In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis *9/3*
 (c) City or town Overland
(If outside city or town limits, write "RURAL") *NR.*
 (d) Street No. 2500 Wismer Road
(If rural, give location)
 (e) Citizen of foreign country? No *1* (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Raymond Francis Slane

3. (b) If veteran, name war No 3. (c) Social Security No. 702-09-6732

4. Sex Male *0* 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Faye M. Slane 6. (c) Age of husband or wife if alive 56 years
 7. Birth date of deceased October 11, 1888.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 6 12 hr. min.

9. Birthplace St. Louis, Missouri. *0*
(City, town, or county) (State or foreign country)

10. Usual occupation Chief Clerk

11. Industry or business St. Louis-Southwestern Ry. Co.

12. Name Frank Slane

13. Birthplace Illinois. *1*
(City, town, or county) (State or foreign country)

14. Maiden name Eva Mouse

15. Birthplace Missouri *0*
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Faye M. Slane

(b) Address 2500 Wismer Road, Overland, Mo.

17. (a) Burial (b) Date thereof APRIL 25 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Calvin F. Reutz Funeral Home

(b) Address 4828 Natural Bridge Blvd.

19. (a) APR 24 1945 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23rd
 year 1945 hour 3:20 minute A. M.

21. I hereby certify that I attended the deceased from Mar 1 - 1945
 to April 22 1945
 that I last saw him alive on April 22 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac failure acute coronary arteriosclerosis
 Due to Acute Cardiac failure
 Due to Lympho Sarcoma and Hemorrhage
 Other conditions: 55
(Include pregnancy within 3 months of death)
 Major findings: 55
 Of operations: _____
 Of autopsy: Same as above

Duration

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) (c) Means of injury

23. Signature G. L. Krause (M. D. or other)
 Address 3720 Washington Date signed 4/23/45

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

MOTHER FATHER

3720 Washington
2. 3. 0. 0. 0. 0.

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 John A. Miller

Licensed Embalmer No. 4186

P. O. Address St Louis 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3638

1. PLACE OF DEATH:

(a) County St. Louis Ind
(b) City or town St. Louis Ind
(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Raymond Francis Lane, Sr.
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ year _____
7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one year _____ hr. _____ 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) 5-22-45 (b) J.F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
(c) City or town St. Louis
(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 _____

4. DATE OF DEATH Month 4 day 23
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
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)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

11790