S. No. 2
M—5-42
. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 26 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20351

Primary Registration District No. 2000

Registrar's No. 463

1. PLACE OF DEATH:
(a) County: GREENE
(b) City or town: SPRINGFIELD MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 900 W. ATLANTIC ST.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO. (b) County: GREENE
(c) City or town: SPRINGFIELD
(If outside city or town limits, write "RURAL")
(d) Street No.: 900 W. ATLANTIC ST.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: CHARLES M. LANE.
3. (b) If veteran, name war: NONE
3. (c) Social Security No. NONE
4. Sex: MALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: WIDOWER
6. (b) Name of husband or wife: UNK.
6. (c) Age of husband or wife if alive, or if dead, state when and how long married: DEC. years
7. Birth date of deceased: NOV. (Month) 22, (Day) 1865 (Year)

8. AGE: Years 79 Months 6 Days 13 If less than one day hr. min.

9. Birthplace: POLK CO. (City, town, or county) MO. (State or foreign country)
10. Usual occupation: RETIRED TELEGRAPH OPERATOR
11. Industry or business: RAILROAD AGENT.
FATHER
12. Name: CHARLES LANE
13. Birthplace: BATES CO. (City, town, or county) TENN. (State or foreign country)
MOTHER
14. Maiden name: SUSAN RUDD.
15. Birthplace: MAGNOLIA (City, town, or county) ARK. (State or foreign country)
16. (a) Informant: FRED W. LANE
(b) Address: SPRINGFIELD MO.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: JUNE 7-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Green Lawn Cem
18. (a) Signature of funeral director: J.W. Klingner & Co
(b) Address: SPRINGFIELD MO
19. (a) 6-6-45 (Date received local registrar) (b) B. W. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5 year 1945 hour 5 minute 00 A.M.
21. I hereby certify that I attended the deceased from 4/25/, 1945, to 6/5/, 1945, that I last saw him alive on 6/4/, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebrovascular involving R. Lung with chronic	2 yrs
Due to: Bronchitis	
Due to: 1142	
Other conditions: Senility (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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: C. E. Fellers (M. D. or other)
Address: Springfield Mo. Date signed: 6-25-45

994 (Licensed Embalmer's Statement on Reverse Side)

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. 4071

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.