S. No. 2
DM—2-43
v. 5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25031

State File No.

FILED AUG 11 1945

Registration District No. Primary Registration District No. 6076 Registrar's No. 1984

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town KOCH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ROBERT KOCH HOSPITAL 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 59 DAYS (Specify whether years, months or days)
In this community 3 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ST. LOUIS 001
(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3668 WEST PINE 9
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME EVELYN BARRON LANE

3. (b) If veteran, name war NO

3. (c) Social Security No.

4. Sex FEMALE 1

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED 1

6. (b) Name of husband or wife HERSHEL LANE

6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased OCTOBER (Month) 31 (Day) 1923 (Year)

8. AGE: Years 21 Months 10 Days 6 If less than one day hr. min.

9. Birthplace WALNUT GROVE, ARKANSAS 1
(City, town, or county) (State or foreign country)

10. Usual occupation CLERK

11. Industry or business

FATHER
12. Name OTTO BROWN
13. Birthplace KENTUCKY 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name OLLIE HOUSDAN
15. Birthplace ARKANSAS 1
(City, town, or county) (State or foreign country)

16. (a) Informant HOSPITAL RECORD
(b) Address KOCH HOSPITAL

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 8-9-45 (Month) (Day) (Year)
(c) Place: burial or cremation HOXEY ARKANSAS

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd

19. (a) 8-8-45 (Date received local registrar) (b) E. S. M. Gorman M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 6 year 1945 hour 5 minute 15 A.M.

21. I hereby certify that I attended the deceased from JUNE 5, 1945, to AUGUST 6, 1945; that I last saw her alive on AUGUST 5, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: CHRONIC GLOMERULONEPHRITIS	8 mo?
Due to: 136.	
Due to:	
Other conditions: PULMONARY TUBERCULOSIS (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 [illegible] (M. D. or other)
Address Koch Hosp. - Koch Mo. Date signed 8/8/45

7.17

(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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.