

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** OCT 28 1946  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1185

1. PLACE OF DEATH:

(a) County Buehannan  
(b) City or town St. Joseph, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mo. Methodist Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 16 hrs (Specify whether  
In this community 16 hrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buehannan  
(c) City or town St Joseph Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME MARGIE LU LANE

3. (b) If veteran, name war  3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years (Month) (Day) (Year)  
7. Birth date of deceased Oct. 16 1946

8. AGE: Years Months Days If less than one day  
0 0 0 16 hr. 0 min.

9. Birthplace St. Joseph, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business .....

12. Name EARL WARREN LANE

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

14. Maiden name MRS. FRANCIS HALBEY

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

16. (a) Informant EARL LANE

(b) Address Grant City, Mo.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 10/17/46 (Month) (Day) (Year)

(c) Place: burial or cremation F. Leppach Cem.

18. (a) Signature of funeral director Archie C. Durrell

(b) Address Grant City, Mo.

19. (a) Oct. 24, 1946 (Date received local registrar) (b) A. J. Mitchell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17 year 1946 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from Oct 16 at 7:30 am to Oct 17 19... that I last saw her alive on Oct 17 19... and that death occurred on the date and hour stated above.

Immediate cause of death Alcoholism, both lungs Duration 16 hrs.

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 161A

Of autopsy Alcoholism

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) Means of injury .....

23. Signature A. J. Mitchell M.D. (M. D. or other) .....

Address 407 North 2nd St. St. Joseph, Mo. Date signed 10/18/46

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

31620

**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..... *Arch C. Lumber* .....

Licensed Embalmer No. *3252* .....

P. O. Address. *Front City, 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.**