

FILED JUN 12 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15450

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 91 PRIMARY REG. DIST. NO. 5019 Registrar's No. 39

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Andrew</u> <u>4</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u> <u>0210</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Ford nursing home</u>    |  | c. CITY OR TOWN <u>Rawood</u>  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NEAR SAVANNAH</u>   |  |  |   |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>James</u> b. (Middle) <u>Edgar</u> c. (Last) <u>Laney</u> |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>5-29-1956</u>   |   |

|   |                               |  |                                   |  |   |  |
|---|-------------------------------|--|-----------------------------------|--|---|--|
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u> | 8. DATE OF BIRTH <u>6-27-1875</u> | 9. AGE (In years last birthday) <u>70</u>                              | IF UNDER 1 YEAR<br>Months <u>11</u> Days <u>2</u> | IF UNDER 24 HRS.<br>Hours <u>2</u> Min.    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY                                    |                                   | 11. BIRTHPLACE (City and State or Foreign Country) <u>Andrew Co Mo</u> |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |

|   |   |                             |
|---|---|-----------------------------|
| 13a. FATHER'S NAME <u>John Wesley Laney</u> | 13b. MOTHER'S MAIDEN NAME <u>Sarah E Harmon</u> | 14. NAME OF HUSBAND OR WIFE |
|---|---|-----------------------------|

|  |                                     |   |                          |
|--|-------------------------------------|---|--------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Orten M. Laney</u> | ADDRESS <u>Rawood Mo</u> |
|--|-------------------------------------|---|--------------------------|

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>unknown</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u>  |  |  |
|   | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)           | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?                      |

22. I hereby certify that I attended the deceased from 5-22, 1956, to 5-29, 1956, that I last saw the deceased alive on 5-22, 1956, and that death occurred at 12 noon, from the causes and on the date stated above.

|  |                                 |                                |
|--|---------------------------------|--------------------------------|
| 23a. SIGNATURE <u>Ronald [Signature]</u> (Degree or title) | 23b. ADDRESS <u>Savannah Ga</u> | 23c. DATE SIGNED <u>6-1-56</u> |
|--|---------------------------------|--------------------------------|

|   |                            |   |  |
|---|----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>5-31-1956</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>BOLCKOW</u> | 24d. LOCATION (City, town, or county) (State) <u>BOLCKOW, Missouri</u> |
|---|----------------------------|---|--|

|  |  |  |                            |
|--|--|--|----------------------------|
| DATE REC'D BY LOCAL REG. <u>6-7-56</u> | REGISTRAR'S SIGNATURE <u>Lillian Spark</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Breit Funeral Home</u> | ADDRESS <u>Savannah Mo</u> |
|--|--|--|----------------------------|

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

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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *E. C. Breit* .....

Licensed Embalmer No. *26*

P. O. Address *Laurel*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.