

FILED AUG 1 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22662
State File No.

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 222

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Sullivan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Green Castle	
c. LENGTH OF STAY (In this place) 2 days		d. STREET ADDRESS (If rural, give location) No street address	
d. FULL NAME OF HOSPITAL OR INSTITUTION Kirkville Osteopathic Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Leoti		b. (Middle) -----	
c. (Last) Lane		4. DATE OF DEATH (Month) (Day) (Year) July 27, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 29, 1888
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Riley Walters	
13b. MOTHER'S MAIDEN NAME Amanda Myers		14. NAME OF HUSBAND OR WIFE Clinton I. Lane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Nellie Dimmitt, Green Castle			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *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		18b. INTERVAL BETWEEN ONSET AND DEATH 30 hrs 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peripheral Circulatory Collapse		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Respiratory failure DUE TO (c) Arteriosclerotic heart disease		
II. OTHER SIGNIFICANT CONDITIONS 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 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) 4200
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 7-25, 1956 to 7-27, 1956, that I last saw the deceased alive on 7-26, 1956, and that death occurred at 6:41 P.M., from the causes and on the date stated above.

23a. SIGNATURE Wray B. Reid	(Degree or title) DO	23b. ADDRESS Kirkville Osteopathic Hosp, Kirkville Mo	23c. DATE SIGNED 7-27-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 29, 1956	24c. NAME OF CEMETERY OR CREMATORY Green Castle Cemetery	24d. LOCATION (City, town, or county) (State) Green Castle, Mo
DATE REC'D BY LOCAL REG. 7-30-56	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Glenn E. Bent & Son, Brew City, Mo.	

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
Student Embalmer

Signed

Carl P. Heat

Licensed Embalmer No. *4689*

P. O. Address *Green 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.