

Health, Welfare, Public Service, 300-556, Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 28 1956

39560

STATE FILE NUMBER

318

1003

10009

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis,		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital			Length of stay in 1b 6 Wks		d. STREET ADDRESS 2100 Penrose		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Clyde Middle R. Last Lane				4. DATE OF DEATH Month Oct. Day 31, Year 1956					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 19, 1893		9. AGE (In years last birthday) 63 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Worker			10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (City and state or country) Otterville, Illinois,		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Lane				14. MOTHER'S MAIDEN NAME Diantha Bell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Theda Welch, 2100 Penrose				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis							INTERVAL BETWEEN ONSET AND DEATH 1 hour		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) arteriosclerotic cardiac vascular atherosclerosis					2 yrs.		
		DUE TO (c) Korotkoff Syndrome					5 wks.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 4-20-1						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 8/21/56 to 10/31/56 and last saw her alive on 10/31/56 Death occurred at 9:15 a. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Joseph J. Mel				22b. ADDRESS 1901 Madison St			22c. DATE SIGNED 11/2/56		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-1-56	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery			23d. LOCATION (City, town, or county) (State) Jerseyville, Illinois,			
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington,				25. DATE RECD. BY LOCAL REG. NOV 2 1956		26. REGISTRAR'S SIGNATURE Carl Smith MD			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Stanley H. Dign...*.....

Licensed Embalmer No. *H. D.*.....

P. O. Address *H. D.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.