

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001393

STATE FILE NUMBER

251

JAN 28 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V.A. Hospital</b>		Length of stay in lb <b>18 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>2210 E. 9th,</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>CHARLIE</b> Middle <b>LANIER</b> Last <b>LANIER</b>			4. DATE OF DEATH Month <b>1st</b> Day <b>13th</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-13-90</b>	9. AGE (In years last birthday) <b>68 yrs</b>	10. FUNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Custodial</b>	11. BIRTHPLACE (City and state or country) <b>Montgomery, Alabama</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>unknown</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>never married</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year, number of service) <b>Yes WORLD WAR #1</b>	16. SOCIAL SECURITY NO. <b>492-14-3523A</b>	17. INFORMANT <b>V.A. Hospital, K.C., Mo.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary congestion and edema</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Uremia</b>		
DUE TO (c) <b>Hypertensive cardiac disease</b>		
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 checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORKING <input checked="" type="checkbox"/> 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
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21. I attended the deceased from <b>January 5, 1959</b> to <b>January 13, 1959</b> Death occurred at <b>2:50</b> am on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>J. A. TURNER, M.D.</b>	22b. ADDRESS <b>MD V.A. Hospital, K.C., Mo</b>	22c. DATE SIGNED <b>1-13-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-14-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>-</b>	23d. LOCATION (City, town, or county) (State) <b>Montgomery, Alabama</b>
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24. FUNERAL DIRECTOR <b>Mrs. Neek's Mortuary, K.C. Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>1-15-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

**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 *Millard B. Paskin*  
Licensed Embalmer No. *5013*  
P. O. Address *N.C. Me.*

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.