Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 59-002612

FILED JAN 21 1959 Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY: St Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: BONNETERRE — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Bonne Terre — Length of stay in 1b: 2 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY: St Francois
c. CITY OR TOWN: Flat River — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 10 Lake Drive — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: William — Middle: Fenton — Last: Lane

4. DATE OF DEATH: Month: Jan. — Day: 14 — Year: 1959

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: June 2, 1908

9. AGE (In years last birthday): 50 — 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): aircraft worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Frankclay, Mo

12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME: Manuel Lane

13b. MOTHER'S MAIDEN NAME: Mary Glore

14. NAME OF HUSBAND OR WIFE: — — — — — —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII Feb 41

16. SOCIAL SECURITY NO. 497-07-8191

17. INFORMANT: Manuel Lane — Address: FIAT River, Mo

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PRIMARY CARCINOMA of Liver — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 1550

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 Dec 10 1958, to Jan 14 1959 and last saw him alive on Jan 14, 1959. Death occurred at 400 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. C. Foster — (Degree or title): MD

22b. ADDRESS: Desloge Mo

22c. DATE SIGNED: 15 Jan 59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Jan. 16 1959

23c. NAME OF CEMETERY OR CREMATORY: Glore Cem.

23d. LOCATION (City, town, or county) (State): Stony Point, Mo

24. FUNERAL DIRECTOR: Bent L. Boyer — ADDRESS: Leadwood Mo

25. DATE RECD. BY LOCAL REG.: Jan. 17, 1959

26. REGISTRAR'S SIGNATURE: Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

JAN 22 195

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 .....

Licensed Embalmer No. 3441

P. O. Address Leadwood 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.