Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004303

STATE FILE NUMBER 7

FILED JAN 26 1959 Registration District No. 373 Primary Registration District No. 4544 Registrar's No. 7

1. PLACE OF DEATH
a. COUNTY WEBSTER
b. CITY OR TOWN NIANGUA — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO
b. COUNTY WEBSTER
c. CITY OR TOWN NIANGUA MO — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First HARRY Middle H Last LANE

4. DATE OF DEATH Month JAN Day 20 Year 1959

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH APR 20 1889

9. AGE (In years last birthday) 69 — 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) RET FARMER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) MISSOURI

12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME HENRY LANE

13b. MOTHER'S MAIDEN NAME FLORA JAMESON

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) WW I

16. SOCIAL SECURITY NO.

17. INFORMANT JEAN SINGER Address MARSHFIELD MO

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ACUTE CIRCULATORY FAILURE	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	CORONARY THROMBOSIS	
DUE TO (c)	ARTERIOSCLEROSIS	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4261

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

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 DID NOT ATTEND to PUBLIC HEALTH OFFICER and last saw her/him alive on
Death occurred at about 12:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) MD

22b. ADDRESS Marshfield, Mo.

22c. DATE SIGNED 1/22/59

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

23b. DATE 1-23-1959

23c. NAME OF CEMETERY OR CREMATORY MISSION HOME

23d. LOCATION (City, town, or county) WEBSTER Co (State) MO

24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD ADDRESS

25. DATE RECD. BY LOCAL REG. JAN 22 1959

26. REGISTRAR'S SIGNATURE [signature]

(Licensed Embalmer's Statement on Reverse Side)

JAN 27 1959

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 George Stapp

Licensed Embalmer No. 7161

P. O. Address [illegible]

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.