

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029998

FILED VS AUG 17 1959

74

Primary Registration District No. 3052

Registrar's No. 265

STATE FILE NUMBER

DED

|   |  |   |   |  |  |  |  |
|---|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  |  |  |  |
| a. COUNTY <u>Pettis</u>   |  | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>                          |   | Length of stay in lb <u>30 yr.</u>   |  | c. CITY OR TOWN <u>Sedalia</u>   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R. F. D. #2</u>                                    |  | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                         |   | d. STREET ADDRESS (If outside, give location) <u>514 East Saline</u>   |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>H.</u> Last <u>LANE</u>  |  |   |   | 4. DATE OF DEATH Month <u>Aug</u> Day <u>11</u> Year <u>1959</u>   |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>   |   | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>2-22-1901</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>                       |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanic</u>   |   | 9. AGE (last birthday) <u>58</u>   |  | IF UNDER 1 YEAR IF UNDER 24 HR   |  |
| 11. BIRTHPLACE (City and state or country) <u>Beaman Mo</u>   |  | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>  |   | Months Days Hours Min.   |  |  |  |
| 13a. FATHER'S NAME <u>Harrison Lane</u>   |  |   | 13b. MOTHER'S MAIDEN NAME <u>Roena Phillips</u> |  |  | 14. NAME OF HUSBAND OR WIFE  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>  |  | 16. SOCIAL SECURITY NO. <u>566-14-4005</u>  |   | 17. INFORMANT <u>Owille Lane</u>   |  | Address <u>R. F. D. #2 Sedalia</u>   |  |
| 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) <u>Pulmonary hemorrhage</u>   |  |   |   | <u>3 hrs.</u>  |  |  |  |
| DUE TO (b) <u>Metastatic carcinoma</u>  |  |   |   | <u>3 mos.</u>  |  |  |  |
| DUE TO (c) <u>Carcinoma of esophagus</u>  |  |   |   | <u>6 mos.</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  |   |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.            |  |
| 19. WAS AUTOPSY PERFORMED? YES <input 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.)   |  |  |  |
| 20c. TIME OF INJURY Hour <u>7:50 AM</u> Month, Day, Year <u>8/11/59</u>   |  |   |   |  |  |  |  |
| 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 <u>7:50 AM</u> to <u>8/11/59</u> and last saw him alive on <u>8/11/59</u>                        |  |   |   | Death occurred at <u>7:50 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.                                    |  |  |  |
| 22a. SIGNATURE <u>D. Maunders D.O.</u> (Degree or title)  |  |   |   | 22b. ADDRESS <u>Sedalia Mo.</u>  |  | 22c. DATE SIGNED <u>8/11/59</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE <u>8-14-59</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Olive Branch</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>Sedalia Rural Mo</u>              |  |
| 24. FUNERAL DIRECTOR <u>McLaughlin Bros Sedalia Mo</u> ADDRESS  |  |   |   | 25. DATE RECD. BY LOCAL REG. <u>8-12-1959</u>  |  | 26. REGISTRAR'S SIGNATURE <u>Francis Sheehey</u>                                   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Harold Tempel, Student Embalmer No. 800

working under my personal supervision.

Student Harold Tempel  
Signature of Student Embalmer

Signed K.P.M. Lra

Licensed Embalmer No. 3153

P. O. Address Sedal

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.