

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031535

FILED VS. SEP 28 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 965

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 25 Yrs		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1317 North 12th St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1317 North 12th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PHILLIP Middle ANDREW Last LANE				4. DATE OF DEATH Month September Day 22 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-1-1889	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (S) Farmer & Custodian			10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	11. BIRTHPLACE (City and state or country) Gentry, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Phillip A. Lane			13b. MOTHER'S MAIDEN NAME Annabell Cofer		14. NAME OF HUSBAND OR WIFE Teresa Lane			
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. 491-10-9033	17. INFORMANT Address Mrs P.A. Lane 1317 No. 12th St. City				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Coronary sclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 5 1/2		
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)				
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 1953 to 9-22-59 and last saw him alive on 9-22-59 Death occurred at 11:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Clarence C. Johnson M.D.				22b. ADDRESS St Joseph Mo			22c. DATE SIGNED 9-23-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-25-59	23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery		23d. LOCATION (City, town, or county) Albany, Mo.		(State)		
24. FUNERAL DIRECTOR H.O. Sidenfaden & Son R.R.4.			ADDRESS St Joseph Mo.		25. DATE RECD. BY LOCAL REG. Sept. 24, 1959	26. REGISTRAR'S SIGNATURE Wm. Clarke Goodell		

DOCUMENT

MEDICAL CERTIFICATION
C.S. DuMont, M.D.

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Robert H. Gaylor

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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.