

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**

FILED VS DEC 9 1959

59-040570

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 5569 Registrar's No. 551

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>St. Clair</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSASCITY</b>		Length of stay in 1b		c. CITY OR TOWN <b>OSCEOLA</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>11206 BANNISTER ROAD</b> INSTITUTION <b>BANNISTER NURSING HOME</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Luther Lane</b>				4. DATE OF DEATH Month Day Year <b>DEC 2, 1959</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT 21 1876</b>		9. AGE (last birthday) <b>83 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>FRANKLIN TEX.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13a. FATHER'S NAME <b>J.F. LANE</b>			13b. MOTHER'S MAIDEN NAME <b>MOLLY MATHEWS</b>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>455 22 9631</b>		17. INFORMANT <b>NURSING HOME RECORDS</b>			Address	
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>Bronchopneumonia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>	
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)						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 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 a.m. p.m. Month, Day, Year		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>June 14, 1958</u> to <u>Dec 2, 1959</u> and last saw him alive on <u>Nov. 20, 1959</u> Death occurred at <u>6:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>William R. Roberts, MD</i>				22b. ADDRESS <b>2108 W. 7th K.C. Mo.</b>				22c. DATE SIGNED <b>3 Dec. 59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>DEC 3, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OSCEOLA CITY</b>		23d. LOCATION (City, town, or county) (State) <b>OSCEOLA MO.</b>			
24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS K.C. MO.</b>				25. DATE RECD. BY LOCAL REG. <b>12-3-59</b>		26. REGISTRAR'S SIGNATURE <i>James Craig</i>			

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *W. Vern Lawler*

Licensed Embalmer No. 4915

P. O. Address K.C. Me

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.