

RI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029478

FILED VS SEP 13 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 268

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Length of stay in 1b		c. CITY OR TOWN <u>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grim-Smith Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>210 E. Washington</u>		Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>Josephine</u> Last <u>Lane</u>				4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-86</u>	9. AGE (last birthday) <u>74</u>	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) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Putman County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>America</u>		
13a. FATHER'S NAME <u>Enoch Rose</u>			13b. MOTHER'S MAIDEN NAME <u>Matilda Johnson</u>			14. NAME OF HUSBAND OR WIFE <u>Neal M. Lane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Record Kirksville, Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) <u>Gen. Arteriosclerosis</u>		
DUE TO (c) _____							<u>3 YRS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CORONARY Thrombosis</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ a.m. _____ p.m.		Month, Day, Year _____							
20d. INJURY OCCURRED 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>8-16-60</u> to <u>9-5-60</u> and last saw her ^{her} _{him} alive on <u>9-5-60</u> Death occurred at <u>7:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>Kirksville, Mo.</u>				22c. DATE SIGNED <u>9-8-60</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>9-7-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Cemetery</u>		23d. LOCATION (City, town, or county) <u>Putman Co. Mo.</u>		(State) _____		
24. FUNERAL DIRECTOR <u>Harris & Harris, Kirksville, Mo.</u> ADDRESS _____			25. DATE RECD BY LOCAL REG. <u>9-8-60</u>		26. REGISTRAR'S SIGNATURE <u>Doris W. Rathoff</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

J. B. JONES, M.D.

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 B. Namis

Licensed Embalmer No. 4219
P. O. Address Kirksvill

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