

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1 1960

5208 - 60-038445

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5208 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>30 YRS</u>		c. CITY OR TOWN <u>Kansas City</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>General Hosp</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3409 Euclid</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>H</u> Middle <u>L.</u> Last <u>LANE</u>				DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</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>1/10/1904</u>	
9. AGE (last birthday) <u>56 YRS</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>2</u>		IF UNDER 24 HR Hours <u>2</u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEER HALL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>		11. BIRTHPLACE (City, and state or country) <u>Texas USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>ROBT LEE LANE</u>			13b. MOTHER'S MAIDEN NAME <u>GEORGIA TITUS</u>			14. NAME OF HUSBAND OR WIFE <u>Violet Lane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>442-09-6702</u>		17. INFORMANT <u>VIOLET LANE 3409 EUCLID</u> 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) <u>Cerebral thrombosis c</u> <u>extension hypostatic</u> <u>bronchial Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. - DUE TO (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
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"/> N. <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 <u></u> a.m. <u></u> p.m. <u></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>9/10/1960</u> to <u>10/12/1960</u> and last saw him alive on <u>10/12/1960</u> Death occurred at <u>845 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>H L Dwyer</u> (Degree or title)				22b. ADDRESS <u>2400 Perry St</u>		22c. DATE SIGNED <u>10-17-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-17-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BLUERIDGE LAWN</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO</u>	
24. FUNERAL DIRECTOR <u>C.K. KERFORD FUNERAL HOME, KC. Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>10-17-60</u>		26. REGISTRAR'S SIGNATURE <u>H-L-Dwyer</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
H. L. Dwyer

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *C. Kenneth Ruffolo*

Licensed Embalmer No. 4491

P. O. Address Riverside

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.