

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041132

Registration District No. 149 Primary Registration District No. COFFEE ~~For Dist. Jackson~~ 5477 STATE FILE NUMBER

AMENDED

FILED NOV 17 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Coffey	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Burlington	
Length of stay in 1b 9 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3660 Summit Street		d. STREET ADDRESS (If outside, give location) Riverside Hotel	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last LANE	4. DATE OF DEATH Month October Day 30 Year 1961
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/5/1872	9. AGE (last birthday) 89	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Water Dept.	11. BIRTHPLACE (City and state or country) Burlington, Kansas	12. CITIZEN OF WHAT COUNTRY USA.
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13a. FATHER'S NAME James Lane	13b. MOTHER'S MAIDEN NAME (Unknown) McGinnis	14. NAME OF HUSBAND OR WIFE Not Known
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Spanish Amr.	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT (Daugh) Maude Brädmeyer, Kan. City, Mo.
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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) Arteriosclerotic heart disease		?
DUE TO (b) Generalized Arteriosclerosis		?
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of prostate	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
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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.) _____
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20c. TIME OF INJURY Hour _____ A.M. _____ P.M. _____	Month, Day, Year _____
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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 _____
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21. I attended the deceased from 10/20/61 to 10:30/61 and last saw ^{her} him alive on 10/30/61
Death occurred at 10:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. G. Leitch (Degree or title)	22b. ADDRESS 808 s. 15 Blue Springs Mo	22c. DATE SIGNED 10/31/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/31/61	23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery	23d. LOCATION (City, town, or county) Burlington, Kansas
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24. FUNERAL DIRECTOR Daniels Bros., F.H., K.C.K.	ADDRESS _____	25. DATE RECD. BY LOCAL REG. 11-2-61	26. REGISTRAR'S SIGNATURE Ruth Long
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BY AFFIDAVIT OF **C. G. Leitch**

[Handwritten signature]

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.