N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Adair

Township ____ or Village ____ or City Kirksville (NO. 614 S. Florence St.; 4 Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 4 File No. 14

Primary Registration District No. 3001 Registered No. 163

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Benjamin Franklin Lamkin

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White ~~Male~~

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Jan 7 - 1836 (Month) (Day) (Year)

AGE: 77 yrs. 3 wks mos. 2 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Insurance
(b) General nature of industry, business, or establishment in which employed (or employer): Fire Insurance

BIRTHPLACE (City or town, State or foreign country): Rising Sun Indiana

PARENTS

NAME OF FATHER: Judson Lamkin

BIRTHPLACE OF FATHER (City or town, State or foreign country): New Hampshire

MAIDEN NAME OF MOTHER: Barbara Ellen Dyer

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Near Rising Sun.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Irene Lamkin Richards

(ADDRESS) No 4 Reed - Oil City Pa.

Filed Jan 31, 1914. A W Parrish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan 30 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 10, 1913, to Jan 30, 1914, that I last saw him alive on Jan 30, 1914, and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Senility

9 5 B

1 6 8

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) Organic Heart Trouble

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Dobson M. D.

Jan 31, 1914 (Address) Kirksville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Forest Cemetery

DATE OF BURIAL: Feb 1 1914

UNDERTAKER: H. C. Wilson

ADDRESS: Kirksville

Revised United States Standard Certificate

MISSOURI STATE BOARD OF HEAI
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occu
hospital or in
give its NAME
of street and nu

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., ...
(Month) (Day)

I HEREBY CERTIFY, that I attended decease

....., 191...., to.....;

that I last saw h.....alive on.....;

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Caus
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIE
RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	.....
UNDERTAKER	ADDRESS

Be sure to place the proper number on the place of death, so that it may be properly classified. Exact statement of OCCUPATION is very important.