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

Do not use this space.

21331

1. PLACE OF DEATH
County Jackson
Registration District No. 399
File No.
Township Kaw
Primary Registration District No. 1002
Registered No. [illegible]
City Kansas City (No. K.C. General Hospital St. ________ Ward)

2. FULL NAME Lambert J. R.

(a) Residence. No. 5007 Olive St., 15 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Widowed

5a. If Married, Widowed, or Divorced HUSBAND OF (OR) WIFE OF No Record

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 10 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	69	2	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Iowa

PARENTS
10. NAME OF FATHER Jno. Lambert
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) No Record
12. MAIDEN NAME OF MOTHER No record
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) No record

14. INFORMANT Record Clerk
(Address) Kansas City Gen'l Hosp

15. FILED 7/5, 1927 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-2- 1927

17. I HEREBY CERTIFY, That I attended deceased from 6-25, 1927, to 7-2-, 1927, that I last saw him alive on 7-2-, 1927, and that death occurred, on the date stated above, at 1:55 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
13A
108
31
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) Pulmonary T. B.
(duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) George C. Lee, M. D.
7/3, 1927 (Address) General Hosp K. C. Mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Memorial Park
DATE OF BURIAL 7/5/1927

20. UNDERTAKER Mrs. C. L. Foster
ADDRESS K. C. Mo.

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.