

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

Do not use this space.

9058

1. PLACE OF DEATH

County Jackson
Township Kear
City Kansas City (No. _____)

Registration District No. 399
Primary Registration District No. 1002
Mercy Hospital

File No. _____
Registered No. 234
St. _____ Ward _____

2. FULL NAME

Willard Lamb
(a) Residence. No. 913 S. Oyle St., _____ Ward. _____
(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 7-1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
		<u>3</u>	<u>10</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Kansas

10. NAME OF FATHER James Lamb

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Edwardsville
(STATE OR COUNTRY) Kansas

12. MAIDEN NAME OF MOTHER Virgie Maxwell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Missouri

14. INFORMANT Harvey Lamb
(Address) 913 S. Oyle St

15. FILED 3/19 287 M. M. Conroy REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-17 1928

17. I HEREBY CERTIFY, That I attended deceased from 1/31 1928, to March 17, 1928, that I last saw him alive on March 16, 1928, and that death occurred, on the date stated above, at 4:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bro Starvation MARASMUS
from Biliary Stenosis

CONTRIBUTORY (SECONDARY) Broncho-Pneumonia

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

19. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Gas Infection
(Signed) H. L. Dwyer, M.D.
3/18 1928 (Address) Medical Arts Bldg NCMO

*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 Maple Hill Cemetery DATE OF BURIAL Mar 19- 1928

20. UNDERTAKER Daniels Bros ADDRESS 644 Kansas Ave N.C.M.

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.

WITH CONTINUING INTEREST THIS IS A PERMANENT RECORD

