

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.

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

Do not use this space.

10550

1. PLACE OF DEATH

County Jackson

Registration District No.

Township 2nd

Primary Registration District No.

City Kansas City(No. Kansas City Genl Hosp)

File No.

Registered No. 11191

St. Ward

2. FULL NAME

Lambert Martha(a) Residence. No. 5400 Bales St. 16 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

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

Jan 1 1852

7. AGE

YEARS

MONTHS

DAYS

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

7711

8. OCCUPATION OF DECEASED

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

Housewife

(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)

Missouri

10. NAME OF FATHER

David Curtis

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

12. MAIDEN NAME OF MOTHER

Dr. Beard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

No record

14.

INFORMANT
(Address)Reverend ClerkKans. City Genl Hosp

15.

FILED

3/29 m. m. (Crown)

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-1 1929

17.

I HEREBY CERTIFY, That I attended deceased from

2-22 1929 to 3-1 1929that I last saw him alive on 3-1 1929 and that death occurred, on the date stated above, at 6:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Stomach46 1/4

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. B. Williams, M. D.3-2 1929 (Address) Em Hosp KC 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

DATE OF BURIAL

Brookfield Mo3-2 1929

20. UNDERTAKER

ADDRESS

Mr. E. L. ForsterK. B. Mo

