

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

Do not use this space.

32807

4031

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 9th & Main, Garage)

Registration District No. 399
Primary Registration District No. 1002

File No. 4031
Registered No. _____
St. _____ Ward _____

2. FULL NAME Wayne Lumpkin

(a) Residence. No. 3612 Troost St. 6 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 5, 1904

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
26 6 29

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hostler
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer 9th & Main Garage

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Myron Lumpkin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Minnie Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo.

14. INFORMANT Coroners Record
(Address) Kansas City, Mo

15. FILED 10-4-30 W. H. Howe REGISTRAR
ant

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-4-1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental fall skull.
1888 2:11 P
1888 2:11 M
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Fell from a motorcycle
while riding (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 Autopsy Inspection
(Signed) Stanley Dr. Hall, M. D.
. 19 _____ (Address) Regulatory Bureau

*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 Jamesport, Mo. DATE OF BURIAL 10-5-30
19

20. UNDERTAKER R. V. Lindsey & Sons, Inc. ADDRESS City

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.

RECEIVED WITH UPDATING INK—THIS IS A PERMANENT RECORD

