

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

399

14231

1. PLACE OF DEATH
 County Jackson Registration District No. 1002
 Township Kear Primary Registration District No. 1002
 City Kansas C. D. Mo. (No. Quinn's Hospital) St. _____ Ward _____

2. FULL NAME Infant Brockway
 (a) Residence No. 4911 E. 27 St. 14th Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 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.

File No. _____
 Registered No. 1746 St. _____ Ward _____

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 None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-12-31

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 0 hrs. or 25 min.

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) None
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) R. C. Mo.
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Claude H. Lamb
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Forest City Iowa
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER LaVaughn Brockway
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ketherville Iowa
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Bonnie Lee Lane
 (Address) 4911 E. 27th

15. FILED 4/14 1931 M. M. Croone
 REGISTRAR W. W. W.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-12 1931
 17. I HEREBY CERTIFY, That I attended deceased from 4-12 1931, to 4-12 1931, that I last saw h. l. o. alive on 4-12 1931, and that death occurred, on the date stated above, at 8:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature
7 mths gestation
159 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 157 (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) Harry S. Lane, M. D.
4/12 1931 (Address) 4911 E 27

*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 Impel Hill Cemetery DATE OF BURIAL April 18 1931
 20. UNDERTAKER P. G. Jensen ADDRESS 2512 Helix

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.

Fairmount
4911 E 27th