

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

34986
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kansas City Primary Registration District No. 1002 Registered No. 3961
 (c) City _____ (d) Street No. St. Joseph Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 263 Baby Lockhart St. Coville Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 14 - 1939
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 1 1/2
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kc Mo.
 FATHER 13. NAME O E Lockhart
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gulfport Mo.
 MOTHER 15. MAIDEN NAME Loraine Estes
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Palo Mo.
 17. INFORMANT (ADDRESS) O E Lockhart Coville, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Coville Mo. DATE Oct 15 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alapanklaude Palo Mo.
 20. FILED Oct 15 39 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 14, 1939
 22. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1939, to Oct 14, 1939
 I last saw her alive on Oct 14, 2:30 P.M. 1939. Death is said to have occurred on the date stated above, at 2:30 P.M.
 The principal cause of death and related causes of importance were as follows:
 1) Hydrocephalus
 2) Spinal lipoma
 Date of onset Birth
 Other contributory causes of importance: _____
 Name of operation None Date of _____
 What test confirmed diagnosis? Autopsy Was there an autopsy? Yes
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) D. R. Ladden M. D.
 (Address) St. Joseph Hospital

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

NOV 14 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.