

No. 2
4-13-40
-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34313**

RECEIVED NOV 12 1940

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. **3829**

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: St. Joseph Hospital
(d) Length of stay: In hospital or institution 1 Day
In this community 1 Day

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town 3925 East 39th
(d) Street No. Kansas City Mo
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John Lampton

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 2 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Missouri (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Marcus Lampton

13. Birthplace Paris Kansas (City, town, or county) (State or foreign country)

14. Maiden name Alice Ann Hamer

15. Birthplace St. Joseph Mo (City, town, or county) (State or foreign country)

16. (a) Informant Marcus Lampton

(b) Address 3925 E. 39th

17. (a) Burial (b) Date thereof Oct 3 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Frank J. Baker Co.

(b) Address 20 N. Duwess

19. (a) 10-3-40 (b) M. M. Morrow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3
year 1940 hour 8 minutes 05 AM

21. I hereby certify that I attended the deceased from Oct 2
1940 to Oct 3 1940
that I last saw h. _____ alive on Oct 3 1940
and that death occurred on the date and hour stated above.

Immediate cause of death 2 mo. premature
Induced labor
Due to Toxemia of Mother

Duration _____
18 hr.
2 wh.
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Other conditions (Include pregnancy within 3 months of death) 159

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Frank J. Baker (M. D. or _____)
Address 1103 Grand Ave Date signed 10/3/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, fact should be so stated above.