

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 182-117  
Registrar's No. 5131

FILED DEC 22 1943

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
647 West 59th Street, /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no.  
In this community 4 years, (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 647 West 59th Street,  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Katharine Uel Lamkin

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

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

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

7. Birth date of deceased August 30 1939  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
4 3 54 hr. min.

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

10. Usual occupation child

11. Industry or business X

12. Name Charles F. Lamkin, Jr.

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

14. Maiden name Jane Ray Johnson,

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

16. (a) Informant Charles F. Lamkin, Jr.

(b) Address 647 West 59th St., Kansas City, Mo.

17. (a) Removal (b) Date thereof 12-5-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keytesville, Missouri

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 12-6-43 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 4th  
year 1943 hour 9:00 minute a. M.

21. I hereby certify that I attended the deceased from Aug 1940 19   to Dec 4 1943;  
that I last saw her alive on Dec 3 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema Duration 2 days

Due to Myocardial Failure  
Progressive Muscular Dystrophy  
Due to Compensated 156

Other conditions (Include pregnancy within 3 months of death)

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) Means of injury \_\_\_\_\_  
23. Signature Phyllis S. Watson (M. D. or other) \_\_\_\_\_  
Address 200 W. 47th St. Date signed 12/6/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

300 W. 47  
Astors - Mid Plaza  
Bldg.  
Dr. ~~Teacher~~ R.M.

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 *John H Hurley*

Licensed Embalmer No. *4050*

P. O. Address *Kansas City, Mo*

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.