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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 21 1945

State File No. 29163

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8045

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis Children's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether
In this community 8 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Jasper 999

(c) City or town West Liberty 11
(If outside city or town limits, write "RURAL")

(d) Street No. — (If rural, give location) NR

(e) Citizen of foreign country? no (Yes or No)

If yes, name country no

3. (a) PRINT FULL NAME Robert Joseph Lamkin

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced no

6. (b) Name of husband or wife —

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

7. Birth date of deceased 4 (Month) 27 (Day) 45 (Year)

8. AGE: Years 0 Months 4 Days 16 If less than one day 0 hr. 0 min.

9. Birthplace Olney Ill (City, town, or county) Illinois (State or foreign country)

10. Usual occupation child

11. Industry or business —

FATHER
12. Name Lester Lamkin
13. Birthplace (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Mary Ochs
15. Birthplace Mary (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Mary Lamkin
(b) Address West Liberty, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-14-45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Marie, Ill.

18. (a) Signature of funeral director Alberti H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) SEP 14 1945 (Date received local registrar) (b) J. Bredell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 13
year 45 hour 3 minute 35 P.M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death abdominal tumor

Due to

Due to 57

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature R. J. Bettner (M. D. or other)
Address [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Albert L. Hoppe

Licensed Embalmer No. 2971

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.