V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32753

FILED OCT 29 1945

Registration District No. 149 — Primary Registration District No. 1002. — Registrar's No. 4264

1. PLACE OF DEATH:

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution 2 hrs 15 min (Specify whether years, months or days)
In this community 2 hrs. 15 min

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay 24

(c) City or town Liberty Mo. 5
(If outside city or town limits, write "RURAL")

(d) Street No. R.R. # 2 6
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Louis B Lambert Jr.

3. (b) If veteran, name war No

3. (c) Social Security No. none

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 26 (Day) 1945 (Year)

8. AGE: Years | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Excelsior Springs Mo (City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business —

MOTHER FATHER

12. Name Louis B. Lambert

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

14. Maiden name Katherine Kraft

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

16. (a) Informant Mrs. John A. Graf

(b) Address R# 2 Liberty Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Mo

18. (a) Signature of funeral director Church-Tucker Co

(b) Address Liberty Mo

19. (a) 10-27-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 16 day
year 1945 hour 3 minute 05 P. M.

21. I hereby certify that I attended the deceased from Oct 16-1 PM 1945 to Oct 16-3:15 PM 1945; that I last saw h[illegible] alive on October 16 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hydrocephalus	Since birth.
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 1570	
Major findings: Of operations	
Of autopsy	

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 A. M. Geiken (M.D. or other)

Address 1624 Independence Date signed 10-16-45

(Licensed Embalmer's Statement on Reverse Side) Belg.

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~~ not

....., Registered Apprentice No....., working under my personal supervision.

Signed Edgar A. Chase

Licensed Embalmer No. 331

P. O. Address Lowell Mass

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.