

FILED APR 5 1946

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 81

1. PLACE OF DEATH

(a) County Cole
(b) City or town Jefferson City
(c) Name of hospital or institution St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week (Specify whether
In this community 1 week
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Union
(If outside city or town limits, write "RURAL")
(d) Street No. 1/4 west of town (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME JO ANN LAMPKIN

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

4. Sex Female 5. Color White 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 Sept 10 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 16 hr. min.

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

10. Usual occupation Child

11. Industry or business _____

12. Name Jo Ann Lampkin

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

14. Maiden name Arlene Hoff

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

16. (a) Informant Jo Ann Lampkin
(b) Address Union, Mo.

17. (a) Removal (b) Date thereof 3-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director [Signature]
(b) Address 707 1/2 E. 11th St.

19. (a) 4-2-46 (b) R. P. Darris (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Mar day 26 year 1946 hour 2 minute 46 M.

21. I hereby certify that I attended the deceased from 3-20-46 to 3-26-46, 1946

that I last saw her alive on 3-26-46, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Enteritis acute hemorrhagic

Due to _____

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

Major findings: Of operations _____

Of autopsy As above

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) (c) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed 3-27-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

0
5
4

PHOTO

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 4-4-46

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 J. R. Anderson
Licensed Embalmer No. 3641
P. O. Address gumbo

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.