DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 8 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20696

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 37

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

1. PLACE OF DEATH:

(a) County Jackson (Rural)
(b) City or town Kansas City Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 95th nd Holmes 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State aKansas (b) County Wyandotte 91
(c) City or town Kansas City 14
(If outside city or town limits, write "RURAL")
(d) Street No. 1308 Grandview 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country .....

3. (a) PRINT FULL NAME Elizabeth Lamb

3. (b) If veteran, name war No

3. (c) Social Security No. .....

4. Sex 3 /

5. Color or race Wh

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife Single

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

7. Birth date of deceased Jan. 11 1926 (Month) (Day) (Year)

8. AGE: Years 20 Months 5 Days 8 If less than one day ..... hr. ..... min.

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

10. Usual occupation Stenographer

11. Industry or business Mutual Insurance Co

FATHER
12. Name Michael Lamb
13. Birthplace Wyandotte Kansas / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Pauline L. Musil
15. Birthplace Kansas City Kans / (City, town, or county) (State or foreign country)

16. (a) Informant Michael Lamb
(b) Address 1308 Grandview

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6 20 46 (Month) (Day) (Year)
(c) Place: burial or cremation St. Johns Kansas City Kans

18. (a) Signature of funeral director Wornall Funeral Home
(b) Address Kansas City Mo

19. (a) 6/25/46 (Date received local registrar) (b) Dr. Annie G. Hedges (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 19 year 1946 hour 9 25 minute P M.

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

	Duration
Immediate cause of death Fracture of neck	
Due to Auto Trauma	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy no History + Inspection

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accident 48
(b) Date of occurrence 6-19-46
(c) Where did injury occur? 95th Holmes Jackson Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? public place (Specify type of place)
While at work? no (e) Means of injury Auto Trauma

23. Signature James Walker (M. D. or other) Coroner 3
Address 1424 [illegible] Date signed 6-20-46

156

(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.....

Licensed Embalmer No.....2810

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—3-45
P I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20 July

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 378

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Elizabeth Lamb

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 11 (Day) 1926 (Year)

8. AGE: Years 20 Months 5 Days 8 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June Day 19
year 1946 hour minute 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

Fracture of Neck

Due to Auto Trauma
(Auto & Truck)

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 17008 20

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) Accident

(b) Date of occurrence 6-19-46

(c) Where did injury occur? 95th & Holmes, Jackson Co Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place
(Specify type of place)

While at work? no (e) Means of injury Auto Trauma & Truck

23. Signature James C. Walker, Coroner (M. D. or other)

Address 1424 Professional Bldg Date signed 6-20-46

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

19568

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