

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4548

No. 300
10-48

FILED OCT 20 1954

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 35 yrs.		STREET ADDRESS (If rural, give location) 10 128 N. Drury 30680	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 128 N. Drury			

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) _____ c. (Last) LAMB			4. DATE OF DEATH (Month) (Day) (Year) 9 26 54		
5. SEX D Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2/28/1875	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Car - man		10b. KIND OF BUSINESS OR INDUSTRY M.O.P. RR	11. BIRTHPLACE (City and State or Foreign Country) Rock Island, Illinois		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME James Lamb	13b. MOTHER'S MAIDEN NAME Isabelle Russell	14. NAME OF HUSBAND OR WIFE Mrs. Stacey Lamb
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 702-14-9894	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Stacey Lamb-128 N. Drury-Kansas City, Mol
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Unknown 4500 36 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis, generalized		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anuria			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 9-26, 1954 to 9-26, 1954, that I last saw the deceased alive on 9-26-54, 1954, and that death occurred at 9:20 P.M. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J.E. Castles M.D.	23b. ADDRESS 1002 Argyle Buidling, K. C. Mo.	23c. DATE SIGNED 9-27-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/28/54	24c. NAME OF CEMETERY OR CREMATORY Green Lawn	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 9-28-54	REGISTRAR'S SIGNATURE neva minshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-McGilley-Eykar-Kansas City, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

JC Coombs
Chicago
No. 5037

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, Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Melvin Borteaue*

Licensed Embalmer No. *490*
P. O. Address *KCM*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.