

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009513

STATE FILE NUMBER

Registration District No. 164 Primary Registration District No. 8032 Registrar's No. 39

AMENDED

FILED VS MAR 13 1961

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WARRENSBURG Township</u>		c. CITY OR TOWN <u>WARRENSBURG</u>	
Length of stay in 1b <u>3 mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 MILE E. WARRENSBURG</u>		d. STREET ADDRESS (If outside, give location) <u>1 MILE E.</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JALIA CHRISTINA LAMPMAN</u>			4. DATE OF DEATH Month Day Year <u>MAR. 10, 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 11, 1929</u>	9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>VERSAILLES MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>HENRY W. THOSS</u>		13b. MOTHER'S MAIDEN NAME <u>DIANA KINDRICK</u>		13c. NAME OF HUSBAND OR WIFE <u>JAMES S. LAMPMAN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO.</u>		17. INFORMANT Address <u>THELMA BYRNE KANSAS CITY, MO.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>generalized arteriosclerosis</u>	<u>1 yr</u>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from 2-2-61 to 3-10-61 and last saw her <sup>her</sup> alive on 3-10-61  
Death occurred at 11:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. Lee Cooper MD</u>	22b. ADDRESS <u>Warrensburg Mo</u>	22c. DATE SIGNED <u>3-10-61</u>
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23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>REMOVED</u>	23b. DATE <u>MAR. 11, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GLEASTED CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>MORGAN CO., MO.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>KIDWELL FUNERAL HOME WARRENSBURG MO</u>	25. DATE RECD. BY LOCAL REG. <u>MAR. 11, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Savannah Custerfield</u>
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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Raymond C. Forbes

Licensed Embalmer No. 4626

P. O. Address Versailles, Mo.

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.