

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

11454

1. PLACE OF DEATH
 County Linn Registration District No. 318
 Township Springfield Primary Registration District No. 2001
 City Springfield (No. 779 College) St. _____ Ward _____
 2. FULL NAME Harling K. Lambird
 (a) Residence. No. 779 College St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 4 yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

File No. _____
 Registered No. 264
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Doris Dillio
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 16-1862
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
64 6 9
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.
 10. NAME OF FATHER Woodford Lambird
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.
 12. MAIDEN NAME OF MOTHER Angie Loney
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. S. P. Lambird
 (Address) 779 College St.
 15. FILED Apr 27 1927 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-23-27
 17. I HEREBY CERTIFY, That I attended deceased from Mo. _____, 1927, to 4-24-1927 and that I last saw him _____ alive on 4-24-1927 and that death occurred, on the date stated above, at 12:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio-sclerosis
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) all
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE DIED (SEAS, CONTINENT, CITY OR TOWN) _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) L. S. Goff, M. D.
425 - 1925 (Address) Springfield Mo.
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Angelwood CEMETERY DATE OF BURIAL 4-27-27
 20. UNDERTAKER W. H. Harve ADDRESS Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECORD

MAY 27 1927

