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

Do not use this space.

35800

1928

1. PLACE OF DEATH
County: Webster
Township: Grant
City: ..... (No. ..... St. ..... Ward)

Registration District No. 896
Primary Registration District No. 6199

File No. .....
Registered No. 38

2. FULL NAME: William Lamb

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): unknown 1839

7. AGE: Years 88 | Months unknown | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(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) Indiana

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT: Floyd Setterman
(Address) Strafford Mo R4

15. FILED 11/30, 1927 J R Bruce REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 13 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 8, 1927, to Nov 13, 1927, that I last saw him alive on Nov 8, 1927, and that death occurred, on the date stated above, at 8 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Brights Disease (Chronic Nephritis)
12.
11.
~~Old~~ 12 9 A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): old age
..... (duration) 2 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) M. Highfill, M. D
Nov 13, 1927 (Address) Marshfield

*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: Mt Pisgah
DATE OF BURIAL: 11/14 1927

20. UNDERTAKER: H. D. McMahan
ADDRESS: Marshfield

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.

6/27