

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

(No. **6650 Southwest**)

File No. **35045**

Registered No. **9744**

St.

Ward.....

2. FULL NAME

(a) Residence. No. **6650 Southwest** St. **13** 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)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Josephine Lambert

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

May 29 - 1867

7. AGE

YEARS *62*

MONTHS *4*

DAYS *2*

If LESS than 7 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

T. Hardwood Finisher

(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)

Germany

10. NAME OF FATHER

Fred W. Lambert

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14. INFORMANT

(Address)

*Mrs. Josephine Lambert
6650 Southwest Ave.*

15. FILED

107 - 2 1929

Max B. Stokloff

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Oct. 1 1929

I HEREBY CERTIFY, That I attended deceased from *10-1 1929* to *10-1 1929*, and that I last saw him alive on *10-1 1929*, and that death occurred, on the date stated above, at *7 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute dilatation of heart, & aortic disease

34 72A Aortic insufficiency (duration) 1 yrs. mos. ds. CONTRIBUTORY (SECONDARY) Syphilis (duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Auscultation*

(Signed) *Victor S. Sailer*, M. D.

Oct 2 . 1929 (Address) 2759 Sulphur

*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

Valhalla

DATE OF BURIAL

Oct 4 1929

20. UNDERTAKER

Walter Helden

ADDRESS

233 S. Main

WRITE IN INK, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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