

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.

NOV 24 1930

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

Do not use this space.

32693

1. PLACE OF DEATH

County HarrisonRegistration District No. 334Township BethanyPrimary Registration District No. 4197City St. Louis (No. 1)File No. 497Registered No. 1St. 1 Ward

2. FULL NAME

(a) Residence. No. 1 St. 1 Ward. 1

(Usual place of abode)

(If nonresident, give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Divorced

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

Do not know

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

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

77--

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

Inmate of County House

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Indiana

10. NAME OF FATHER

Philip Lambert

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Do not know

12. MAIDEN NAME OF MOTHER

Betty Nossaman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Do not know

14.

INFORMANT
(Address)Clifford Chandler
Bethany Mo

15.

FILED 11/10/30W J Harned

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

10-15-1930

17.

I HEREBY CERTIFY, That I attended deceased from 10-12-1930 to 10-15-1930that I last saw him alive on 10/14, 1930, and that death occurred, on the date stated above, at 7 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of Stomach466

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

440

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W J Harned M. D.10-15-1930 (Address) Bethany 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

DATE OF BURIAL

Hobbs Cemetery10-18 1930

20. UNDERTAKER

ADDRESS

S. M. HarnedBethany Mo

