

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 4 1936

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.

Township

Primary Registration District No.

City

(No. City Hospital No. 1

B. 9336

Dorothy Lambert

2. FULL NAME

(a) Residence, No.
(Usual place of abode)

1021 South 13th St.,

22 Ward.

(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

female

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)

Jan 28, 1936

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, ...hrs.
or min.

0

8

11

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.

nil

9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

St. Louis, Missouri

FATHER

13. NAME

Benjamin Lambert

14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

Missouri

MOTHER

15. MAIDEN NAME

Lillian Medick

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

Missouri

17. INFORMANT

Hosp. Info. M.H. Kent
(Address) City Hospital No. 1

18. BURIAL, CREMATION, OR REMOVAL

PLACE St. Matthews DATE Oct. 12 1936

19. UNDERTAKER

J. W. McLaughlin
(Address) 2301 Lafayette
JCT 11 1936 J. W. McLaughlin

20. FILED

Registrar

791

1003

39217

File No.

Registered No.

10249

St. Ward)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10 / 9 / 36 , 19

22. I HEREBY CERTIFY That I attended deceased from
9/20/36 , 19 , to 10/9/36 , 19I last saw her alive on 10/9/36 , 19 . Death is said
to have occurred on the date stated above, at 5.55p.m.

The principal cause of death and related causes of importance were as follows:

Date of onset

*Supercardiac - Bacillary
Phthisis non - Calculous
Pneumonia*

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

M. D.

(Address) City Hospital No. 1

