

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

JUN 24 1939

20028

Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 875
 (b) Township Center Primary Registration District No. 3039 Registered No. 126
 (c) City Nevada (d) Street No. 719 E. Allison St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Dorris Jacob Lambert
 (a) Residence, No. 719 E. Allison St. ☐ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Martha Lambert</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 17, 1859</u>		
7. AGE <u>79</u>	YEARS <u>9</u>	MONTHS <u>24</u>
OCCUPATION		11. Total time (years) spent in this occupation <u>60 yrs.</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Carpenter</u>		
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year) <u>March 1939</u>		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>		
FATHER	13. NAME <u>Christopher Columbus Lambert</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Washington</u>	
	15. MAIDEN NAME <u>Lambert</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Washington</u>	
17. INFORMANT (ADDRESS) <u>Doris J. Lambert</u> <u>Nevada, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Springfield, Mo.</u> DATE <u>May 17, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>W. W. Lambert</u> <u>Nevada, Mo.</u>		
20. FILED <u>May 17, 1939</u> <u>Allen V. Hays</u> <u>Local Registrar</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 1939 to May 16, 1939
 I last saw him alive on April 13, 1939. Death is said to have occurred on the date stated above, at 5:30 A.M.
 The principal cause of death and related causes of importance were as follows:
Heart block
 Date of onset 3-3-39

Other contributory causes of importance:
Myocarditis
Arteriosclerosis

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 _____, 19____
 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? No
 If so, specify _____
 (Signed) W. W. Lambert M. D.
 (Address) Nevada, Mo.

92c

RECEIVED

District Health Officer No. 7,
District File Number 7-39-881

Date Filed 6-6-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by James H. [unclear]

....., Registered Apprentice No.
working under my personal supervision.

Signed Lloyd B. Winslett

Licensed Embalmer No. 3857

P. O. Address W. Wada, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

20.028

Do not use this space.

PLACE OF DEATH

(a) County Vernon
(b) Township Nevada
(c) City Nevada

Registration District No. 875
Primary Registration District No. 3039

Registered No. 126

(d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Dorris Jacob Lambert
(a) Residence, No. _____ St. _____
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED was

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
79 9 29

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19__

19. FUNERAL DIRECTOR
(ADDRESS)

20. FILED 5-17 1977 allen V. Hays
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-16 1977

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19__

I last saw him alive on _____, 19__ Death is said

to have occurred on the date stated above, at _____ m.

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

Heart Block

131

Other contributory causes of importance:
Myocarditis
systemic following
Chronic interstitial nephritis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19__

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) E. R. King, M. D.

(Address) Nevada

100-100000

100-100000

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