FILED AUG 19 1940

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

Do not use this space.

25798

File No. 1
Registered No.

1. PLACE OF DEATH
County Monroe
Township South fork
City (No. St. Ward)
Registration District No. 386
Primary Registration District No. 5784

2. FULL NAME Mrs Vagina L 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: Female
4. COLOR OR RACE: White
5. ~~SINGLE, MARRIED~~, WIDOWED, OR ~~DIVORCED~~ (write the word): Widowed

5A. ~~IF MARRIED, WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF Geo P. Lamb

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-12-1856

7. AGE: Years 83 | Months 9 | Days 1 | If LESS than 1 day, ....hrs. or ....min.

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

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

FATHER
13. NAME Robert P. Smith
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

MOTHER
15. MAIDEN NAME Palmer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

17. INFORMANT Mrs Edith M. Jones (Daut)
(ADDRESS) Melvin Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Santa Fe Mo DATE March 15 1940

19. UNDERTAKER Snyder & Hanger
(ADDRESS) Santa Fe Mo

20. FILED March 13 1940 Roberts Drake
Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 13 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 1 1940 to Mar 13 1940
I last saw h. alive on Mar 10 1940 Death is said to have occurred on the date stated above, at 12:30 p.m.
The principal cause of death and related causes of importance were as follows:

Cerebral Thrombosis — Date of onset Mar 1-40

Other contributory causes of importance: Arteriosclerosis

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? No
If so, specify

(Signed) J. E. Brown M. D.
(Address) Perryville Mo.

516

No. 2B
2-21-40
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 25-798

Registration District No. 586 Primary Registration District No. 5784 Registrar's No.

1. PLACE OF DEATH:
(a) County Monroe
(b) ~~City or town~~ South Fork
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Monroe
(c) City or town Rural
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mrs Vaginia L. Carnes
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced wd
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 83 Months 9 Days 1 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 13
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY