

No. 2
-11-10-39
5-17-39
I X21492

FILED SEP 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27084**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **6980**

1. PLACE OF DEATH:

(a) County St. Louis.
 (b) City or town St. Louis.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Josephine Heitkamp Hospital.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution One Month
 In this community 50 Years. (Specify whether years, months or days)

8. (a) PRINT FULL NAME Elenor Lamb. **510**

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John T. Lamb. 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased May 10, 1872
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>3</u>	<u>7</u>	_____ hr. _____ min.

9. Birthplace Ireland. **5**
 (City, town, or county) (State or foreign country)

10. Usual occupation At Home.

11. Industry or business _____

12. Name Thomas Jackson
 13. Birthplace Ireland. **5**
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Burke.
 15. Birthplace Ireland. **5**
 (City, town, or county) (State or foreign country)

16. (a) Informant John T. Lamb.
 (b) Address 4441 Arco Ave.

17. (a) Burial (b) Date thereof 8-20-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly
 (b) Address 3840 Lindell Blvd.

19. (a) AUG 18 1940 (b) J. H. Bredeck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis, Mo. **18**
 (If outside city or town limits, write "RURAL")

(d) Street No. 4441 Arco Ave.
 (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17th.
 year 1940 hour 6.00 minute _____ A. M.

21. I hereby certify that I attended the deceased from 3-16-40
 _____, 19____, to 8-17, 1940
 that I last saw her alive on 8-16, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cocaine Poisoning

Due to _____

Due to HO
 Other conditions None
 (Include pregnancy within 3 months of death)

Major findings: None
 Of operations _____

Of autopsy None

Duration _____
 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 Thos. Schuck (M. D. or other) **1**
 Address 1703 1/2 Grand Date signed 8-20-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Dr Philip Ashurst
1703 So Grand
3-4

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

Signed Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Landell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)
If this body is not embalmed, above space should be left blank.