

DEC 11 1940

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

38970  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Jefferson Registration District No. 421  
 (b) Township Popeheim Primary Registration District No. 3375  
 (c) City Herculaneum (d) Street No. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 102

## 2. PRINT FULL NAME

(a) Residence, No. Herculaneum, Mo. (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 (write the word) single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 26 - 1940  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 2 10

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) Herculaneum, Mo.  
(STATE OR COUNTRY)

FATHER 13. NAME Walter Lambert  
 14. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.  
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Genevieve Gordon  
 16. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.  
 (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Walter Lambert, Herculaneum, Mo.18. BURIAL, CREMATION, OR REMOVAL 11-7-40 Herculaneum, Mo.19. FUNERAL DIRECTOR (NAME) Fink and Co.  
(ADDRESS) Festus, Mo.20. FILED 11/7, 1940 J. E. Rutledge, M.D.  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 6, 1940  
 22. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1940 to Nov 6, 1940  
 I last saw him alive on Nov 5, 1940 Death is said to have occurred on the date stated above, at 6:50 A.M.  
 The principal cause of death and related causes of importance were as follows:

Pneumonia Date of onset 11/1/40

Other contributory causes of importance:

Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? None 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) Ernest J. Deun M. D.  
 (Address) Herculaneum, Mo.

107W

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

Licensed Embalmer No.

P. O. Address

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **38970**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **421**

Primary Registration District No. **5575-**

Registrar's No.

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

1. PLACE OF DEATH:

- (a) County: **Jefferson**  
(b) City or town: **Madison**  
(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  
In this community years, months or days)

3. (a) PRINT FULL NAME

**Chas E. J Lambert**

3. (b) If veteran,  
name war

3. (c) Social Security  
No.

4. Sex **m**

5. Color or  
race **w**

6. (c) Single, widowed, married,  
divorced **s**

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

Months

Days

If less than one day

**2**

**10**

h min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

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)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County  
(c) City or town (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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **11** day **6**  
year **1940** hour minute M.

21. I hereby certify that I attended the deceased from  
19 to 19  
that I last saw him alive on  
and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho  
pneumonia  
primary!**

Due to **No complications**

Due to **107N**

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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

S-38970 1940