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3-40  
7-39  
DC23159

FILED JAN 15 1941

7911

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town **ST. LOUIS, MO.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**6050 MAPLE AVE**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **MARY E. LAMBERT**

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 **WIDOW**

6. (b) Name of husband or wife **CHAS. W. LAMBERT** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **AUG. 22<sup>ND</sup> 1870**  
(Month) (Day) (Year)

8. AGE: Years **70** Months **3** Days **6** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **AT HOME**

11. Industry or business **RETUSED HOUSEWIFE**

12. Name **UNKNOWN**

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 **Walter Lambert**  
(b) Address **6050 MAPLE AVE**

17. (a) **BURIAL** (b) Date thereof **12-2-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY**

18. (a) Signature of funeral director **L. M. Muller**

(b) Address **5165 DEMAR BLVD**

19. (a) **DEC 1 1940** (b) **J. H. Bredrup**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED **1003**

(a) State **Mo.** (b) County \_\_\_\_\_  
(c) City or town **ST. LOUIS**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **6050 MAPLE AVE**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **29**  
year **1940** hour **1** minute **15 PM**

21. I hereby certify that I attended the deceased from **Nov 26**, 19**40** to **Nov 29**, 19**40**  
that I last saw h**ER** alive on **NOV. 29**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute cardiac dilatation**

Due to **Aterial degeneration  
Atherosclerosis  
and definite heart disease**

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations **97**

Of autopsy \_\_\_\_\_

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 **1**

23. Signature **H. G. Tucker** (M. D. or other) \_\_\_\_\_  
Address **5902 Maple** Date signed **11/29/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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 Howard Rowland

Licensed Embalmer No. 3114

P. O. Address Orlando Fla

**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, fact should be so stated above.**