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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23131
Registrar's No. 5483

FILED AUG 28 1941
Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME **Mary T. Lambert**

3. (b) If veteran, name war..... 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Robert Charles Lambert** 6. (c) Age of husband or wife if alive **1869**
7. Birth date of deceased **July** (Month) (Day) (Year)

8. AGE: Years **71** Months **11** Days **24** If less than one day hr. min.

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

10. Usual occupation **At Home**

11. Industry or business.....

12. Name **John Sweeney** 13. Birthplace **Ireland** (City, town, or county) (State or foreign country)

14. Maiden name **D. E.** 15. Birthplace **Ireland** (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address **4800 Easton Ave.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7 - 3-41** (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter's Cemetery**

18. (a) Signature of funeral director **Cullinane Bros.** (b) Address **1710 N. Grand Blvd.**

19. (a) **JUL 2 1941** (Date received local registrar) (b) **J. W. Bredich** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **741 Bayard Ave.** (If rural, give location)
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1** year **1941** hour **8 53** minute **0** P. M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw him alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....

Multiple Pulmonary Abscesses. Fracture of right femur. Suffered in fall from her bed to the floor.

Due to **in Room 27. St. Anne Home**

5301 Page Blvd on June 20, 1941

Other conditions **About 730 PM** (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (specify) **Accident**

(b) Date of occurrence **June 20, 1941**

(c) Where did injury occur? **St. Louis** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **St. Anne Nursing Home** (Specify type of place) (Specify type of place)

23. Signature **Alfred J. Morris** (M. D. or other) Address **St. Louis** Date signed **7/2/41**

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.....

Fred Frick

Licensed Embalmer No. 3186

P. O. Address St. Louis, 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, fact should be so stated above.