

FILED JUN 26 1942
Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 561

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Days (Specify whether
In this community 45 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1603 1/2 Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6th.
year 1942 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from approx.
Jan 8, 1941 to June 6, 1942
that I last saw her alive on June 6, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death:
1. Acute heart failure (few hours)
(arteriosclerotic heart disease)?
2. Repeated cerebral vascular accidents (hemorrhages)
Due to Complete Paralysis 1 1/2 yrs
3. Hypertension
4. Diabetes mellitus ?

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?

23. Signature: Wm B. Pasch MD (M. D. or other) MD
Address: St. Joseph, Mo. Date signed: 6-8-42
(Specify type of place) (Specify means of injury)

3. (a) PRINT FULL NAME Anna Laura Lambert

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

4. Sex female / 5. Color or race white / 6. (a) Single, widowed, married, divorced, widow 2 divorced widow

6. (b) Name of husband or wife Thomas Jefferson Lambert 6. (c) Age of husband or wife if alive years 25 1887 (Month) (Day) (Year)

7. Birth date of deceased December 25 1887 (Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 11 If less than one day hr. min.

9. Birthplace Unknown / Massachusetts (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name John Carter

13. Birthplace Nova Scotia Canada 2 (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Christie

15. Birthplace Unknown Massachusetts (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. A. Keen

(b) Address 1603 Third Ave., St. Joseph, Mo.

17. (a) Burial (b) Date thereof 6/10/1942 (Burial, cremation, or removed) (Month) (Day) (Year)

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 13th. & Farson St., St. Joseph, Mo.

19. (a) June 8, 1942 (b) (Date received local registrar) (Date)

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

FILED IN NO. OF ST. JOSEPH

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.....

Geo E Daniel

Licensed Embalmer No. 3300 Missouri

P. O. Address St. Joseph, Missouri.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 2-61
648

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)
In this community 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1603 3rd Avenue
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Anna Laura Lambert
3. (b) If veteran, name war no 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 Thomas Jefferson Lambert 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 25-1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 10 If less than one day _____ min.

9. Birthplace Unknown Massachusetts
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry of business _____

12. Name John Carter

13. Birthplace Bruce Scotia, Canada
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Christie

15. Birthplace Unknown Massachusetts
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. A. Keeg
(b) Address 1603 3rd Ave., St. Joseph Mo

17. (a) Burial (b) Date thereof 6-10-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery St. Joseph Mo

18. (a) Signature of funeral director Walter Neishoff
(b) Address 13th & Saragyn St. St. Joseph Mo
19. (a) 6-10-48 (b) Rose Herzog
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6 year 1948 hour 4 minute 0 A. M.

21. I hereby certify that I attended the deceased from approx Jan 8 1948 to June 6 1948 that I last saw him/her alive on June 6 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: (1) acute heart failure
(2) arteriosclerotic heart disease
(3) repeated cerebral vascular accidents (hemorrhage) complete paralysis
(4) hypertension
(5) diabetic mellitus
Other conditions: _____
(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) _____
(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? _____

23. Signature Wm. B. Rosin MD (M. D. or other) MD
Address St. Joseph Mo Date signed 6-8-48

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

SUPPLEMENT

MOTHER FATHER

194

S-20717