DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 15 1942

Registration District No. 181

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30763

Primary Registration District No. 3058

Registrar's No.

1. PLACE OF DEATH:

58 (a) County Linn

1 (b) City or town Brookfield (If outside city or town limits, write "RURAL" and name of township)

2 (c) Name of hospital or institution: 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 6 months

2. USUAL RESIDENCE OF DEACESED:

(a) State Missouri (b) County Linn 58

(c) City or town Carrollton 1 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

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

3. (a) PRINT FULL NAME NANCY JANE 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 Widowed

6. (b) Name of husband or wife J. E. Lambert

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb (Month) 4 (Day) 1846 (Year)

8. AGE: Years 96 Months 8 Days 2 If less than one day hr. min.

9. Birthplace Indiana! (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Wise

13. Birthplace Don't Know (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Lovy Isaacs

15. Birthplace Don't Know (City, town, or county) (State or foreign country)

16. (a) Informant's own signature X Elvie Jane Fordham

(b) Address 703 Brookfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8-1942 (Month) (Day) (Year)

(c) Place: burial or cremation Rydding

18. (a) Signature of funeral director James M. Daugherty

(b) Address Marceline Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6 year 1942 hour 6 minute 10 A.M.

21. I hereby certify that I attended the deceased from March, 1935 to Oct 5, 1942, that I last saw her alive on Oct 5, 1942, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Senility	—
Due to: Acute Tracheo bronchitis	5 dy
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 1 0 6 a	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Roy P. Haley (M.D. or other) MD

Address Brookfield Mo Date signed 10-8-42

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-1739 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Dale Bunch

Licensed Embalmer No. 4088

P. O. Address Marceline 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, above space should be left blank.

No. 2B
—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30763

Registration District No. 184 Primary Registration District No. 3038 Registrar's No.

1. PLACE OF DEATH:

(a) County: Linn

(b) City or town: Brookfield
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Nancy Jane Lambert

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Feb (Month) 4 (Day) 1848 (Year)

8. AGE: Years 94 Months 8 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) 10-8-1942 (Date received local registrar) (b) N H Cowan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. Day 8 year 1942 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY