

FILED JUL 19 1948 49

Primary Registration District No. 1002

Registrar's No. 2976

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days)
In this community more 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 54
(c) City or town Lexington 3
(If outside city or town limits, write "RURAL") 2
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

William Lambert

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Lillie 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased Jan 4 1874
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 0 If less than one day hr. _____ min. _____

9. Birthplace Mo. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Coal miner

11. Industry or business none

12. Name Henry Lambert

13. Birthplace Ky 1
(City, town, or county) (State or foreign country)

14. Maiden name Martha Grigby

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

16. (a) Informant Lillie Lambert

(b) Address Lexington mo

17. (a) Removal (b) Date there July 4-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington mo

18. (a) Signature of funeral director M. E. Foster

(b) Address 914 Brooklyn

19. (a) 7-5-43 (b) Dep. T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4th
year 1943 hour 5:10 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 29th 1943 to July 4 1943
that I last saw him alive on 7-4-43 10:30 AM 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Star-gaugulated Heavily Acute Obstruction 18 hrs
12:20

Due to _____

Due to _____

Other conditions Myelocytic leukemia 6 mo-1 yr
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy large spleen, & liver

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Robert W. Smith (M. D. number) _____

Address St. Mary's Hospital Date signed 7-4-43

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

Smith

1884 # *Richard ...*
1884

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

working under my personal supervision.

Signed.....

Licensed Embalmer No. *1624*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2976

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(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 William Lambert

3. (b) If veteran, name war no 3: (c) Social Security No. no

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife Lilhe Nordstuck 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased..... (Month) (Day) (Year)

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

9. Birthplace..... (City, town, or county) (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)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 7-5-43 (b) P. E. Brown (Date received local registrar) (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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day..... Year..... Hour..... Minute..... M.

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

Duration

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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

S-23921