

No. 9-4-41
17-3
X2848

FILED OCT 25 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35931**

Registration District No. **333** Primary Registration District No. **3074** Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Scott**
(b) City or town **Sikeston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Sikeston General
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **New Madrid**
(c) City or town **Canalou**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **J.F. Lamb (James Franklin)**

3. (b) If veteran, name war **Civil War** 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **W 2**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **8 4 1843**
(Month) (Day) (Year)

8. AGE: Years **100** Months **1** Days **14** If less than one day hr. _____ min.

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

10. Usual occupation **Farming**

11. Industry or business **Retired**

12. Name **JAMES Elijah Lamb**

13. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

14. Maiden name **(Nancy) Unknown**

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

16. (a) Informant **Pearl Beardsley**

(b) Address **Canalou Mo.**

17. (a) **Burial** (b) Date thereof **9/19/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sikeston Mo.**

18. (a) Signature of funeral director **H.W. Albritton**

(b) Address **Sikeston Mo.**

19. (a) **10-1-43** (b) **Levin Largent**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **18**
year **1943** hour **12** minute **55** P.M.

21. I hereby certify that I attended the deceased from **9-15**
_____ 19 **43**
that I last saw him alive on **9-18** _____ 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia & Shock** Duration **3 days**

Due to **fractured leg hip** ✓
old age

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 **072**

(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 **21**

23. Signature **Dr. James M. D. L.** (M. D. or other) _____

Address **Wolhouse, Mo.** Date signed **9/27/43**

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

RECEIVED

District Health Office No. 2,

District File Number 143-1352

Date Filed 10-20-13

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.....

Not Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Hunter Albritton

Licensed Embalmer No. 4210

P. O. Address Sikeston Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1100
Registrar's No. _____

Registration District No. 333 Primary Registration District No. 3074

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

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Likeston
(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)

3. (a) PRINT FULL NAME J. F. Lamb.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 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: Aug 4 1874
(Month) (Day) (Year)

8. AGE: Years 100 Months 1 Days _____
(Unless than one day)

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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 Aug 18
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Branchio pneumonia & shock

Due to _____

Due to Fractured left hip

Other conditions old age
(Include pregnancy within 3 months of death)

Major findings: fell at home PHYSICIAN _____
Of operations _____
Of autopsy Aug 18
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 Emerson M.D. (Specify type of place) _____ (M. D. or other) _____
Address North house mo (c) Means of injury _____
Date signed 10-30-43

SUPPLEMENTARY

35931