

FILED AUG 12 1944

Registration District No. 63

Primary Registration District No. 5251

Registrar's No.

1. PLACE OF DEATH:
(a) County Chariton
(b) City or town Mendon Rural
(c) Name of hospital or institution: Mendon
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Chariton
(c) City or town Mendon Rural 21
(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 U

3. (a) PRINT FULL NAME Catharine H. Lamb

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 married
6. (b) Name of husband or wife FRANK P. Lamb 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 21 1883
(Month) (Day) (Year)

8. AGE: Years 61 Months 20 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Mitchel Hawkins
13. Birthplace SALINE Co Mo
14. Maiden name Elizabeth PATTIE
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant FRANK P. Lamb

(b) Address Mendon Mo

17. (a) Burial (b) Date thereof 7/13/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Cemetery

18. (a) Signature of funeral director W. J. [unclear]
(b) Address Mendon Mo

19. (a) 7-13-1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 11
year 1944 hour _____ minute 1 P M.

21. I hereby certify that I attended the deceased from about
1 year 19____ to 19____;
that I last saw her alive on July 11 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure
resulting from
chronic curvatur

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
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 W. B. Lucas M.D. (M. D. or other) 7/13/44
Address Mendon Mo Date signed _____

1232

1232

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

8-11-44

AUG 31 1944

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

Licensed Embalmer No.

P. O. Address

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.

A. S. Leonard

3970

Wendover

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. me 9
Registrar's No. _____

Registration District No. 65 Primary Registration District No. 5251

1. PLACE OF DEATH:
(a) County Chariton
(b) City or town Rural Mendon Mo
(If outside city or town limits, give 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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Catharine H. Lamb
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 m

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

7. Birth date of deceased June 21 1885
(Month) (Day) (Year)

8. AGE: Years 41 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 _____

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)
(Burial, cremation, or removal)

(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 July year 1944 hour 9 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 Heart failure resulting from

Duration _____

Due to chiguni uremia
At the 3rd and last child birth
Due to Wry was taken with a severe
attack of uremia and never fully
recovered after the birth
Other conditions _____ (Include pregnancy within 3 months of death)
the 25 years afterward

PHYSICIAN
Major findings: _____
Of operations _____
W. B. Lucas, M.D.
Of autopsy _____
Mendon, Mo.
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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

MOTHER FATHER

131 P

24400