

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Iron
(b) City or town Rural; Iron
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7 miles S. of Belleview
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution life (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Della May Lambert

3. (b) If veteran,

name war no

3. (c) Social Security

No. none

4. Sex fem

5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased April 9
(Month) (Day) (Year)

8. AGE:

Years 19 Months 2 Days 27
If less than one day hr. min.

9. Birthplace Iron County
(City, town, or county)

Mo.
(State or foreign country)

10. Usual occupation at home

11. Industry or business

12. Name Melvin Lambert

13. Birthplace Iron County
(City, town, or county)

Mo.
(State or foreign country)

14. Maiden name Stella Strickland
Graniteville Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Melvin Lambert

(b) Address Belleview Mo.

17. (a) burial (b) Date thereof 7-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Belleview Mo.

18. (a) Signature of funeral director Norman White & Sons

(b) Address Ironton Mo.

19. (a) July 14/44 (b) Mrs. J. C. Richards
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 7 miles S of Belleview
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6
year 1944 hour 11 minute 30 R.

21. I hereby certify that I attended the deceased from May 18 1944 to July 6 1944
that I last saw her alive on July 1 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hodgkins Disease
Duration 3 yrs.

Due to

Due to

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?

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

23. Signature J. H. Wathkins (M. D. or other)

Address Farmington Mo. Date signed 7-10-44

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

RECEIVED

District Health Officer No. 4
District File Number 844-4211
Date Filed 8-11-44

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.....

Amel J. White

Licensed Embalmer No. 8012

P. O. Address Emtun Ave

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.