

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 5 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36095

State File No.

Registration District No. 318 Primary Registration District No. 1000 Registrar's No. 10149

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Insulation Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11-20-1944 to 11-20-1944
(Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME

Max Lambert

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife

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

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

abt. 78

hr. min.

9. Birthplace

Germany

(City, town, or county) (State or foreign country)

10. Usual occupation

Nil

11. Industry or business

12. Name

Jacob Lambert

13. Birthplace

Germany

(City, town, or county) (State or foreign country)

14. Maiden name

Lena Haul

15. Birthplace

Germany

(City, town, or county) (State or foreign country)

16. (a) Informant

Edith V. Brinay

(b) Address

5600 Arsenal St.

17. (a) Anatomical Board

(b) Date thereof 11-20-44

(c) Place: burial or cremation

St. Louis

18. (a) Signature of funeral director

W. R. Risher

(b) Address

2500 Rutger St.

19. (a) NOV 29 1944

(Date received local registrar)

(b) J. J. Brink

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 28
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 808-53rd St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20
year 1944 hour 4 minute 50P M.

21. I hereby certify that I attended the deceased from 11-20
1944 to 11-20 1944

that I last saw him alive on 11-20 and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative heart disease

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)
(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 Dr. Maxwell (M. D. or other)

Address 5600 Arsenal St. Date signed 11-24

(Licensed Embalmer's Statement on Reverse Side)

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

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 comply with the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36095
Registrar's No. 10149

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis
(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

Max Lambert

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 single

6. (b) Name of husband or wife.....

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

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

8. AGE: Years Months Days Unless than one day
alt 78 min.

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

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) (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) JAN 30 1945
(Date received local registrar)

J. F. Bradeau
(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.....
year 1944 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.....

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..... (M. D. or other).....

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

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

SUPPLEMENTARY

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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