S. No. 2
M—5-42
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 9 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9678

Primary Registration District No. 1000

Registrar's No. 238

1. PLACE OF DEATH:

(a) County: GREENE

(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 410 Edith Drive (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: None (Specify whether years, months or days) In this community: 18 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

(c) City or town: Springfield (If outside city or town limits, write "RURAL")

(d) Street No.: 410 Edith Drive (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Ellna Elizabeth Lamb

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

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

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

7. Birth date of deceased: February (Month) 14, (Day) 1856 (Year)

8. AGE: Years 88 Months 1 Days 5 If less than one day hr. min.

9. Birthplace: Quincy, (City, town, or county) Illinois (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: In Home

FATHER
12. Name: UNK.
13. Birthplace: UNK. (City, town, or county) UNK. (State or foreign country)

MOTHER
14. Maiden name: UNK.
15. Birthplace: UNK (City, town, or county) UNK. (State or foreign country)

16. (a) Informant: Mr. Clarence B. Lamb
(b) Address: Springfield, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 22, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: National Cemetery

18. (a) Signature of funeral director: Alma Lohmeyer Funeral Home
(b) Address: Springfield, Missouri

19. (a) 3-21-45 (Date received local registrar) (b) D. W. E. Hardy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19th, year 1945 hour 10:05 minute A. M.

21. I hereby certify that I attended the deceased from March, 1940, to March, 1945, that I last saw her alive on February 20, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocardial failure	20 MIN
Due to: Chronic Myocarditis	10 YRS
Due to: Infirmities of aged	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: None
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: William J. Campion (M. D. or other) D.V.
Address: Springfield, Mo. Date signed: 3-20-45

984

(Licensed Embalmer's Statement on Reverse Side)

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 C. A. Roof

Licensed Embalmer No. 3044

P. O. Address Springfield Mo

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.