s. No. 2
M—2-43
6-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 14 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

17727

State File No.

Registration District No. 5-5-6 Primary Registration District No. 5879 Registrar's No.

1. PLACE OF DEATH:
(a) County Osage
(b) City or town Aud, Bailey Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: At Home
(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)
In this community 82 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Osage
(c) City or town Aud, Mo.
(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 William M. Lamb
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Tillie Duncan
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 4th, 1862 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
82	8	11	hr. min.

9. Birthplace Aud, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Owen Lamb
13. Birthplace Ireland (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Mary Coughlan
15. Birthplace Ireland (City, town, or county) (State or foreign country)
16. (a) Informant Boyd Lamb
(b) Address Aud, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (Month) (Day) (Year)
(c) Place: burial or cremation Bailey Creek
18. (a) Signature of funeral director [signature]
(b) Address Box 144, Linn, Mo.
19. (a) Feb 19, 1945 (Date received local registrar) (b) Esther Souder (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 15th, year 1945 hour 12 minute 45 p M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Heart Disea se	2 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 [signature] Coroner (M. D. or other)
Address Box 144, Linn, Mo. Date signed 2/15/4

570 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 6-13-45

FEB 9 1955

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 Omer L. Jones, Registered Apprentice No. 373, working under my personal supervision.

Signed Victor Buescher

Licensed Embalmer No. 3701

P. O. Address Jefferson City, 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.

S. No. 2B
M—5-43
No I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 256 Primary Registration District No. 5879 Registrar's No.

1. PLACE OF DEATH:

(a) County Osage

(b) City or town Auf Benton Twp
(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)

In this community

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

3. (a) PRINT FULL NAME Wm M. 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased June (Month) 4 (Day) 1842 (Year)

8. AGE: Years 82 Months 8 Days Unless than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Chronic Myocarditis

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

93d

17727