S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

20235

State File No.

Registration District No. 7

Primary Registration District No. 4171

Registrar's No. 46

1. PLACE OF DEATH:
(a) County De Kalb
(b) City or town Clarksdale
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(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 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State California (b) County Los Angeles
(c) City or town Los Angeles
(If outside city or town limits, write "RURAL")
(d) Street No. 170 West 45 Street
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Rosa A. Lambing
3. (b) If veteran, name war —
3. (c) Social Security No. 563-07-2791
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar 3 1881 (Month) (Day) (Year)

8. AGE: Years 64 Months 3 Days 19 If less than one day hr. min.

9. Birthplace St Joseph (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Jacob Beverly
13. Birthplace Ohio (City, town, or county) (State or foreign country)
14. Maiden name Lydia E
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs H. J. Simpson
(b) Address Clarksdale Mo
17. (a) Remove (Burial, cremation, or removal) (b) Date thereof 6-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation Los Angeles Calif.
18. (a) Signature of funeral director Flowman & Son Inc
(b) Address St Joseph Mo
19. (a) 6-25-45 (Date received local registrar) (b) John Clare (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22 year 1945 hour 9 minute 45 P. M.
21. I hereby certify that I attended the deceased from June 21, 1945 to June 22, 1945 that I last saw h alive on June 22, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Thrombosis — 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature M. S. Gale (M. D. or other)
Address Osborn Mo Date signed 6/22/45

1378

(Licensed Embalmer's Statement on Reverse Side)

JUL 9 1945

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.....Robert L. Gaple.....

Licensed Embalmer No.....3308.....

P. O. Address.....St Joseph, 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.