

FILED AUG 20 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 6149

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Six miles S.W. Paines  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Duck Bluff Hosp  
(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 GARRY LEE LAMBERT

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 (1)

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 2 1945  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 4 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Poplar Bluff hospital (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Quintin Lambert

13. Birthplace Black Clarkton Mo. (City, town, or county) (State or foreign country)

14. Maiden name Betty Ruth Wilson

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

16. (a) Informant Dora Wilson

(b) Address Dudley, Mo. Route 1

17. (a) Burial (b) Date thereof 7-5-1945  
(Burial, cremation, or removed) (Month) (Day) (Year)

(c) Place: burial or cremation Dexter, Mo.

18. (a) Signature of funeral director M. L. Shain

(b) Address RISK, MO

19. (a) 8-5-1945 (b) J. J. Starnes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard

(c) City or town Six miles S.W. Paines  
(If outside city or town limits, write "RURAL")

(d) Street No. Dudley Route 1  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

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 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) Natural cause, from heart

(b) Date of occurrence July 4, 1945

(c) Where did injury occur New Paines Stoddard Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
home, on farm

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature W. L. ... (M.D. or other) Chomer

Address Dexter, Mo. Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

July 4, 1945

RECEIVED

District Health Office No. 2,

District File Number 845-1067

Date Filed 8-8-45

**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.**