

BUREAU OF THE CENSUS
FILED JAN 23 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 278Primary Registration District No. 3054

Registrar's No. _____

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:
St. Luke's Hospital
 (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

Charles William Lamb
 3. (b) If veteran, name war I World War 3. (c) Social Security No. 338-10-4352

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Esther Marks 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased Nov. 23, 1915
 (Month) (Day) (Year)

8. AGE: Years 30 Months 1 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Curriculum Dev. Worker

11. Industry or business St. Louis, Mo. Construction

12. Name Charles Lamb

13. Birthplace St. Louis, Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Esther Marks

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

16. (a) Informant William Brueggeman

(b) Address St. Louis, Mo.

17. (a) Burial (b) Date thereof 12/30/45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director W. E. Starnes

(b) Address St. Louis, Mo.

19. (a) 2/30/45 (b) Margaret E. Stephens
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis 56
 (c) City or town St. Louis 1
 (If outside city or town limits, write "RURAL") 0-
 (d) Street No. _____ (If rural, give location) 1
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26
 year 1945 hour 5 minute 40 P.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 Fractured skull
skull

Duration

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) accident 80

(b) Date of occurrence Dec. 26, 1945

(c) Where did injury occur? Get. Railroad Bridge
 (City or town) (County) (State)

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

While at work? yes (Specify type of place) (e) Means of injury skull fracture

23. Signature S. A. Yocum (M. D. or other)

Address St. Louis, Mo. Date signed 12/31/45

NOV 12 1947

JAN 25 1946

DEC 17 1946

JAN 25 1946

RECEIVED
District Health Officer No. 10
District File Number 1-46-18
Date Filed JAN 21 1946

DEC 18 1946

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.....

George O. Wagner, Registered Apprentice No.
working under my personal supervision.

Signed George O. Wagner
Licensed Embalmer No. 3703
P. O. Address Louisiana, 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.

Registration District No. 278 Primary Registration District No. 3054

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Louisiana
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Charles W. 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 _____

7. Birth date of deceased Nov. 23
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 4 11 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) (Date received local registrar) (b) (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 Dec year 1945 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 Skull fracture

Due to hit by steel beam while working on R.R. Bridge

Due to (Repairing Bridge)

Other conditions. (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 1945

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) Skull fracture

23. Signature S.A. Goodin (M.D. or other) (Coroner)

Address Louisiana, Mo. Date signed _____

SUPPLEMENTARY

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

100719

3683

DEC 18 1946

DEC 18 1946

DEC 17 1946

JUN 20 1946