

7. S. No. 2
FORM-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
FILED

6 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18622**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4751**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2mos-3 days
(Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 5653 Delmar Ave.,
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country.....

In this community.....
years, months or days

3. (a) PRINT FULL NAME. MARTHA Lambeth

3. (b) If veteran, name war..... **3. (c) Social Security.** No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9
 year 1946 hour 11:00 minute P M.
 I hereby certify that I attended the deceased from March 14
 19 46 to May 9 19 46
 that I last saw her alive on May 9 19 46
 and that death occurred on the date and hour stated above.

4. Sex female **5. Color or race** white

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

6. (b) Name of husband or wife William Lambeth **6. (c) Age of husband or wife if alive**..... years

7. Birth date of deceased October ? ?
(Month) (Day) (Year)

Immediate cause of death Bronchopneumonia

Due to.....

Due to.....

Other conditions.....
(include pregnancy within 3 months of death)

Major findings:
 Of operations.....

Of autopsy.....

8. AGE: Years abt 65? Months..... Days..... If less than one day.....
hr. min.

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

10. Usual occupation housewife

11. Industry or business.....

12. Name William McKnight

13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant M.A. Renard

(b) Address St. Louis City Hospital, Anatomical Board

17. (a) (Burial, cremation, or removal) **(b) Date thereof** 5-14-46
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director J. F. Bredet While at work (Specify typical day) (Means of inquiry)

(b) Address MAY 28 1946

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?.....

23. Signature R. H. Hubbs (M. D. or other)
 Address 1400 Pratt Date signed 5-10-46

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

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.