

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 11 1947

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 244

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

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institutions 709 W 3rd. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 22 yrs.
years, months or days

3. (a) PRINT FULL NAME Margaret Lamb

3. (b) If veteran, name war

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Park Lamb

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Dec 20 1888
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>6</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation Home maker.

MOTHER FATHER

11. Industry or business _____

12. Name Christopher Davis

13. Birthplace South Wales, /
(City, town, or county) (State or foreign country)

14. Maiden name Mary Elizabeth Davis

15. Birthplace South Wales 4
(City, town, or county) (State or foreign country)

16. (a) Informant Park Lamb

(b) Address 709 W. Third

17. (a) burial (b) Date thereof 7-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director M. Laughlin Bros

(b) Address 519 So. 1st Sedalia Mo.

19. (a) 7-11-47 (b) Betty Yeager
(Date received local registrar) (Registrar's signature) Deputy

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis 80

(c) City or town Sedalia 6
(If outside city or town limits, write "RURAL")

(d) Street No. 709 W. 3rd 4
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9 year 1947 hour 7 minute a.m.

21. I hereby certify that I attended the deceased from July 9 1947 to July 9 1947
that I last saw her alive on July 9 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Occlusion

Due to Hypertension

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature [Signature] (M. D. or other) M.D.

Address Sedalia Mo. Date signed 7/10/47

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

8-8-47

7130 Ar. 101 July 9

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

A. P. M. Cray

Licensed Embalmer No.

3153

P. O. Address

Sedalia

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.