

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31294**
Registration District No. **149** Primary Registration District No. **1002** Registrar's No. **3995**

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Klo
(c) Name of hospital or institution: 413 Cherry
(d) Length of stay: 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Klo
(d) Street No. 413 Cherry
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME SUSIE LAMBERT

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Vel Lambert 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased: 9/30/1881

8. AGE: Years 65 Months 11 Days 18 If less than one day hr. min.

9. Birthplace Georgia

10. Usual occupation Housewife

11. Industry or business

12. Name Sam Ballard

13. Birthplace Georgia

14. Maiden name Unknown

15. Birthplace Georgia

16. (a) Informant Vel Lambert

(b) Address 413 Cherry

17. (a) Removal (b) Date thereof 9/20/47

(c) Place: burial or cremation Mt Calvary B.C.K.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 18 year 1947 hour 6:10 minute a M.

21. I hereby certify that I attended the deceased from Baron, 19 , to , 19 ;

that I last saw h. alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Insufficiency

Due to

Due to

Other conditions 950

Major findings: Of operations

Of autopsy

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?
(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 Janet Walker (M. D. or other)
Address Date signed 9-24-47

Duration
Physician
Underline the cause to which death should be charged statistically.

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 _____

Ray E. Snow

Licensed Embalmer No. *2560*

P. O. Address *N E Md*

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.