

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **44613**

FILED JAN 19 1948

Registration District No. **283**

Primary Registration District No. **3074**

Registrar's No. **17**

1. PLACE OF DEATH:

(a) County **Scott**
(b) City or town **Sikeston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community **Two years**
years, months or days)

3. (a) PRINT
FULL NAME

McKinley Lambert
3. (b) If veteran, **World War II** 3. (c) Social Security No.

4. Sex **Male** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ladie Lambert** 6. (c) Age of husband or wife if alive **27** years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
37 2 0 hr. min.

9. Birthplace **Marianna Ark**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business
12. Name **Tom Lambert** 9
13. Birthplace **unknown** (City, town, or county) (State or foreign country)
14. Maiden name **unknown** 7
15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Wife**
(b) Address **Sikeston MO**

17. (a) **Burial** (b) Date thereof **10-17-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Funeral Home**

18. (a) Signature of funeral director **Orville Taylor**
(b) Address **Sikeston MO**

19. (a) **1-14-48** (b) **Mrs. J. J. Henry**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Scott** 100
(c) City or town **Sikeston** 5
(If outside city or town limits, write "RURAL")
(d) Street No. **225 Fair St.** 2
(If rural, give location) 0
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **14**
year **1947** hour **10** minute **34** 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 **Gunshot wound of head**
Due to **Accident**
Due to

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations **184**
Of autopsy **17**
Underline the cause of 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** 100
(b) Date of occurrence **Oct 14, 1947**
(c) Where did injury occur? **Sikeston, Scott, MO**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home** 3
While at work? **no** (Specify type of place)
(e) Means of injury **Gunshot Wound**

23. Signature **Orville Taylor** (M.D.) **Coroner**
Address **Sikeston MO** Date signed **1-14-48**

RECEIVED

District Health Office No. 2

District File Number 148-80

Date Filed 1-14-48

JAN 19 1948

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. 4052

P. O. Address. East Prairie

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.