No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26705

FILED SEP 8 1948

Registration District No. 46

Primary Registration District No. 3026

Registrar's No. 255

1. PLACE OF DEATH:
(a) County JACKSON
(b) City or town INDEPENDENCE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: INDEPENDENCE SANITARIUM & HOSPITAL 0
(If not in hospital or institution, write street, number, or location)
(d) Length of stay: In hospital or institution TWO WEEKS (Specify whether
In this community NINE YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON 48
(c) City or town INDEPENDENCE 4
(If outside city or town limits, write "RURAL")
(d) Street No. 908 W. MAPLE AVE 4
(If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MRS. LENA J. GRAHAM
3. (b) If veteran, name war NO
3. (c) Social Security No. NO
4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband ~~or wife~~ CHARLES F. GRAHAM
6. (c) Age of husband or wife if alive ---- years
7. Birth date of deceased APRIL (Month) 18 (Day) 1879 (Year)

8. AGE: Years 69 Months 4 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace SIOUX CITY (City, town, or county) IOWA (State or foreign country)
10. Usual occupation none
11. Industry or business NONE

FATHER
12. Name DANIEL F. LAMBERT
13. Birthplace NAUVOO (City, town, or county) ILLINOIS (State or foreign country)

MOTHER
14. Maiden name HARRIET M. BURLEY
15. Birthplace MT. ROSE (City, town, or county) IOWA (State or foreign country)

16. (a) Informant KENNETH L. GRAHAM
(b) Address 614 N. DELAWARE
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 9-2-48 (Month) (Day) (Year)
(c) Place: burial or cremation LAMONI, IOWA
18. (a) Signature of funeral director [signature]
(b) Address 815 W. MAPLE AVE.
19. (a) 9-1-48 (Date received local registrar) (b) [signature] (Registrar's signature) 3549

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug day 31 year 1948 hour 9 minute 47 A.M.

21. I hereby certify that I attended the deceased from Sept 1941 to 8/31 1948 that I last saw her alive on 8/31 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death acute circulatory failure	3 days
Due to Bronchial asthma (intractable)	yrs
Due to	
Other conditions — (Include pregnancy within 3 months of death)	

Major findings: Of operations none 112
Of autopsy see above

PHYSICIAN
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)
(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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Vance E. Link M.D. (M. D. or other)
Address Independence, Mo Date signed 8/31/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

FEB 23 1949

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. 3157

P. O. Address Audrain 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.