

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26632**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **809**

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Taney	
b. CITY (If outside corporate limits, write RURAL and give town or town) Springfield	c. LENGTH OF STAY (In this place) 1 month	c. CITY (If outside corporate limits, write RURAL and give township) Brown Branch	
d. FULL NAME OF HOSPITAL OR INSTITUTION 610 State Street		d. STREET ADDRESS (If rural, give location) U	

3. NAME OF DECEASED (Type or Print)	a. (First) JESSE	b. (Middle) FRANKLIN	c. (Last) LAMBETH	4. DATE OF DEATH (Month) (Day) (Year) Sept. 8, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 26 August 1874	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Mo Laclede County, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Ben Lambeth	13b. MOTHER'S MAIDEN NAME Mary Shockley	14. NAME OF HUSBAND OR WIFE Mable Lambeth
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 531-28-1261	17. INFORMANT'S SIGNATURE OR NAME Violet Hoover	ADDRESS Springfield, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma (abdominal)		3 mos
ANTECEDENT CAUSES			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) involving liver	
		DUE TO (c) and abd. l. nodes	
II. OTHER SIGNIFICANT CONDITIONS			1991
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION Aug 18, 1949	19b. MAJOR FINDINGS OF OPERATION Above	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug 8, 1949** to **Sept 8, 1949** that I last saw the deceased alive on **Sept 8, 1949**, and that death occurred at **2:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Charles C. Lechert, M.D. (Degree or title)	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED Sept 9, 1949
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept 11, 1949	24c. NAME OF CEMETERY OR CREMATORY Garrison	24d. LOCATION (City, town, or county) (State) Garrison Mo
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DATE REC'D BY LOCAL REG. 9-10-49	REGISTRAR'S SIGNATURE W. J. Handley	25. FUNERAL DIRECTOR'S SIGNATURE Fred C. Thome	ADDRESS Springfield Mo
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Ralph H. Pheme

Signed.....
Student Embalmer

Licensed Embalmer No. 3681

P. O. Address Springfield, Missouri

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.