

FILED MAR 27 1950

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9991

Registration District No. 299

Primary Registration District No. 6028

Registrar's No. 3

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County REYNOLDS
 (c) City or town RURAL LESTERVILLE
(If outside city or town limits, write "RURAL")
 (d) Street No. 11 miles NORTH OF LESTERVILLE
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? LIFE years

3. (a) PRINT FULL NAME RACHEL LAMBERT

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife JOHN LAMBERT 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased FEBRUARY 1 1869
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>81</u> | <u>1</u> | <u>1</u> | _____ hr. _____ min. |

9. Birthplace REYNOLDS CO. MO.
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

12. Name JOHN M. STRICKLAND

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name MARY ADELINE BOUNDS

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Lambert

(b) Address Moberly, Missouri

17. (a) BURIAL (b) Date thereof MAR 4 1950
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LAMBERT CEMETERY

18. (a) Signature of funeral director Uncle White

(b) Address Winton, Mo.

19. (a) 3/4/50 (b) C. M. White
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 2
 year 1950 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from FEBRUARY 1st, 1950, to MARCH 2, 1950;
 that I last saw h.e.r. alive on MARCH 1, 1950;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage instant

Due to _____

Due to _____

Other conditions Influenza
(Include pregnancy within 3 months of death) 4 wks.

Major findings:
 Of operations 2 BIV
2 BIV
 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 C. M. White (M. D. or other) M.D.

Address Lesterville, Mo. Date signed 3/4/50

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

39
492

MOTHER FATHER

RECEIVED

3-13-50

District Health Officer No. 6,

District File Number... 3-50-195

Date Filed... 3-17-50

JUL 1 1953

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.