

FILED DEC 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38725

State File No.

318

1003

10194

Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2179			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis,				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 0			
d. FULL NAME OF HOSPITAL OR INSTITUTION Marian Hospital				e. STREET ADDRESS (If rural, give location) 2933 St. Vincent St.			
3. NAME OF DECEASED (Type or Print)		a. (First) Alexandra		b. (Middle) Lambert		c. (Last) Lambert	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April, 15, 1894	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 56		11. BIRTHPLACE (State or foreign country) Albania 8	
13a. FATHER'S NAME Themiou Nastas		13b. MOTHER'S MAIDEN NAME Anastasia Neftas		14. NAME OF HUSBAND OR WIFE Lazar Lambert		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lazar Lambert 2933 St. Vincent St.			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Urinemia II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 9 da. 6 yrs. 3 da.	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 321X			
22. I hereby certify that I attended the deceased from 11-20, 1950, to 11-28, 1950, that I last saw the deceased alive on 11-28, 1950, and that death occurred at 9 A.M., from the causes and on the date stated above.							
23a. SIGNATURE J. J. Lively (Degree or title) M.D.		23b. ADDRESS 2528 So Jefferson		23c. DATE SIGNED 11-29-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/1/50		24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. NOV 30 1950		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE Chulick Und. Co. 1722 S. Jefferson		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Student
Student Embalmer

Signed

Clay A. Chulick

Licensed Embalmer No. 4143

P. O. Address 1722 S. Jefferson

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.