

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **21105**

FILED JUN 30 1952

BIRTH NO. _____		REG. DIST. NO. <u>184</u>		PRIMARY REG. DIST. NO. <u>3038</u>		Registrar's No. <u>184</u>	
1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Brookfield</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Brookfield</u> <u>158th</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McLarney Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>520 West Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>DONALD</u>		a. (First)		b. (Middle) <u>KELLEY</u>		c. (Last) <u>LAMBERT</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>June 19-1952</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>	
8. DATE OF BIRTH <u>June-19-52</u>		9. AGE (in years last birthday) <u>40</u>		10. MONTHS <u>0</u>		11. DAYS <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Brookfield Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Not known</u>		13b. MOTHER'S MAIDEN NAME <u>Donnie Bell Lambert</u>		14. NAME OF HUSBAND OR WIFE <u>Mary E Lambert Brookfield Mo</u>			
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.		17. INFORMANT'S SIGNATURE OR NAME <u>Mary E Lambert Brookfield Mo</u>			
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) <u>Prematurity of Birth</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last: <u>Premature placental separation</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
19a. DATE OF OPERATION <u>6/19/52</u>		19b. MAJOR FINDINGS OF OPERATION <u>Premature placental separation</u>				20. AUTOPSY? YES ☐ NO ☒	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>no</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>no</u>		21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? <u>no</u>			
22. I hereby certify that I attended the deceased from <u>6-19-52</u> , to <u>6-19-</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>6-19-52</u> , 19 <u>52</u> , and that death occurred at <u>9:22 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>K.W. Robinson mo.</u>				23b. ADDRESS <u>211 Linn, Brookfield Mo</u>		23c. DATE SIGNED <u>6/20/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6/19/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery Brookfield</u>		24d. LOCATION (City, town, or county) (State) <u>Mo</u>	
DATE REC'D BY LOCAL REG. <u>6-23-52</u>		REGISTRAR'S SIGNATURE <u>Madeline Stambach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Blacklock Brookfield Mo</u>			

(Licensed Embalmers' Statement on Reverse Side)

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

TESTAMENT

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 Not Embalmed

Licensed Embalmer No. _____

P. O. Address _____

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.