

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 31 1953

State File No. **30163**
7230

BIRTH NO. 47119		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Mo. b. COUNTY ST. LOUIS			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN UNO		4876	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital				d. STREET ADDRESS (If rural, give location) 900 Erskin, 23			
3. NAME OF DECEASED (Type or Print) a. (First) Donald		b. (Middle) Davis		c. (Last) Lambert		4. DATE OF DEATH (Month) (Day) (Year) 7 24 53	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____		8. DATE OF BIRTH 7-24-53	
9. AGE (In years last birthday) _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. 0	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Michael Lambert		13b. MOTHER'S MAIDEN NAME Ora Marie Lawson		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Ora Marie Lawson		ADDRESS 900 Erskin	
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Neonatal anoxia & congenital Stalelania ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Intra cranial hemorrhage DUE TO (c) Precipitate labor. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Marked inflammation & softening of umbilical cord.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) St. Louis St. Louis Missouri			
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? 760.0			
22. I hereby certify that I attended the deceased from 8:45 7-24 1953 , to 10:45 7-24 1953 , that I last saw the deceased alive on 7-24 1953 and that death occurred at 10:45 A. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Robert J. Puestel M.D.				23b. ADDRESS 1325 S. Grand Blvd.		23c. DATE SIGNED 7-24-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 25/53		24c. NAME OF CEMETERY OR CREMATORY St. Matthew Cern.		24d. LOCATION (City, town, or county) (State) Bates & Leavitt Minn Mo	
DATE REC'D BY LOCAL REG. JUL 25 1953		REGISTRAR'S SIGNATURE J. Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE M.D. Bull - Campbell		ADDRESS Marion 516 Delmar	

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

Rex E Campbell

Licensed Embalmer No. *3881*

P. O. Address *St Louis 89*

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, fact should be so stated above.