

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11926

State File No.

FILED MAY 10 1954

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 555L Registrar's No. 68

0460

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

1. PLACE OF DEATH a. COUNTY Howell		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Howell	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN West Plains		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN West Plains, Mo	
c. LENGTH OF STAY (If in this place) 70 yrs.		d. STREET ADDRESS (If rural, give location) Lebo Rte.,	
d. FULL NAME OF HOSPITAL OR INSTITUTION X RURAL X			

3. NAME OF DECEASED (Type or Print) a. (First) John Daniel b. (Middle) Lambe c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 4-13-54
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 6-26-1876	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months 9 Days 17	IF UNDER 24 HRS. 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 X X	11. BIRTHPLACE (State or foreign country) Newport, Ky	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Wm. Lambe	13b. MOTHER'S MAIDEN NAME Martha Trimble	14. NAME OF HUSBAND OR WIFE X
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X (If yes, give war or dates of service) X	16. SOCIAL SECURITY NO. X	17. INFORMANT'S SIGNATURE OR NAME Cecil Lambe, West Plains, Mo ADDRESS
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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, ashenia, 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) CONGESTIVE HEART FAILURE		2 WEEKS
	ANTECEDENT CAUSES *Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CEREBRAL HEMORRHAGE DUE TO (c) HYPERTENSION, ESSENTIAL SENILITY		2 MONTHS ?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331 X	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)
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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?
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22. I hereby certify that I attended the deceased from 3-10 1954 to 4-13 1954, that I last saw the deceased alive on 3-10 1954, and that death occurred at 4:00 m., PM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Jack N. Wilson, M.D.	23b. ADDRESS West Plains, Mo.	23c. DATE SIGNED 4-20-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) B	24b. DATE 4-15th -54	24c. NAME OF CEMETERY OR CREMATORY Evergreen	24d. LOCATION (City, town, or county) (State) West Plains, Mo
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DATE REC'D BY LOCAL REG. 5-3-54	REGISTRAR'S SIGNATURE Beatrice Cook	25. FUNERAL DIRECTOR'S SIGNATURE Robertsons, West Plains, Mo ADDRESS
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JUN 22 1967

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

D. Roberts

Licensed Embalmer No. 3437

P. O. Address West Plain

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.