

FILED JUN 27 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 20178

318

1003

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--|
| BIRTH NO. _____                                                                                                                                                                                                                                                    |                                  | REG. DIST. NO. _____                                                                           |                                                             | PRIMARY REG. DIST. NO. _____                                                                                                                                                                                                                                                                         |                                                                                   | Registrar's No. _____                                                                                                  |                                           |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____                                                                                                                                                                                                                               |                                  |                                                                                                |                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>Reott</u>                                                                                                                                                             |                                                                                   |                                                                                                                        |                                           |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>                                                                                                                                                                              |                                  | c. LENGTH OF STAY (in this place) <u>4 years</u>                                               |                                                             | c. CITY OR TOWN <u>SIKESTON</u>                                                                                                                                                                                                                                                                      |                                                                                   | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |                                           |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL</u>                                                                                                                                                                                             |                                  |                                                                                                |                                                             | e. STREET ADDRESS (If rural, give location) <u>1001</u>                                                                                                                                                                                                                                              |                                                                                   |                                                                                                                        |                                           |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>BERTHA</u>                                                                                                                                                                                                               |                                  |                                                                                                | a. (First) _____ b. (Middle) _____ c. (Last) <u>LAMBERT</u> |                                                                                                                                                                                                                                                                                                      | 4. DATE OF DEATH<br>(Month) <u>JUNE</u> (Day) <u>9</u> (Year) <u>1955</u>         |                                                                                                                        |                                           |  |
| 5. SEX<br><u>female</u>                                                                                                                                                                                                                                            | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>married</u>                       | 8. DATE OF BIRTH<br><u>6-17-1909</u>                        |                                                                                                                                                                                                                                                                                                      | 9. AGE (In years last birthday)<br><u>45</u>                                      | IF UNDER 1 YEAR<br>Months _____ Days _____ IF UNDER 24 HRS.<br>Hours _____ Min. _____                                  |                                           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>                                                                                                                                                    |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>at home</u>                                            |                                                             | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>Sikeston, Mo. 0</u>                                                                                                                                                                                                                         |                                                                                   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                             |                                           |  |
| 13a. FATHER'S NAME<br><u>Herbert Rogers</u>                                                                                                                                                                                                                        |                                  |                                                                                                | 13b. MOTHER'S MAIDEN NAME<br><u>Effie Brown</u>             |                                                                                                                                                                                                                                                                                                      | 14. NAME OF HUSBAND OR WIFE<br><u>George Lambert</u>                              |                                                                                                                        |                                           |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>                                                                                                                                              |                                  |                                                                                                | 16. SOCIAL SECURITY NO.<br><u>none</u>                      |                                                                                                                                                                                                                                                                                                      | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>George Lambert, Sikeston, Mo.</u> |                                                                                                                        |                                           |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Retroperitoneal leiomyosarcoma</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Far-advanced</u><br>DUE TO (c) _____ |                                                                                   |                                                                                                                        | INTERVAL BETWEEN ONSET AND DEATH<br>_____ |  |
| 19a. DATE OF OPERATION<br>_____                                                                                                                                                                                                                                    |                                  | 19b. MAJOR FINDINGS OF OPERATION<br>_____                                                      |                                                             |                                                                                                                                                                                                                                                                                                      |                                                                                   | 20. AUTOPSY?<br>YES <input checked="" 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)<br>_____                                                                                                                                                                                                                                             |                                                                                   | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____                                                           |                                           |  |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                             |                                  | 21f. HOW DID INJURY OCCUR<br><u>197X</u>                                                       |                                                             |                                                                                                                                                                                                                                                                                                      |                                                                                   |                                                                                                                        |                                           |  |
| 22. I hereby certify that I attended the deceased from <u>3-17-55</u> , 19____, to <u>6-9-55</u> , 19____, that I last saw the deceased alive on <u>6-9-55</u> , 19____, and that death occurred at <u>4:30P</u> m., from the causes and on the date stated above. |                                  |                                                                                                |                                                             |                                                                                                                                                                                                                                                                                                      |                                                                                   |                                                                                                                        |                                           |  |
| 23a. SIGNATURE (Degree or title)<br><u>John Thompson M.D.</u>                                                                                                                                                                                                      |                                  |                                                                                                |                                                             | 23b. ADDRESS<br><u>1515 Lafayette Avenue</u>                                                                                                                                                                                                                                                         |                                                                                   | 23c. DATE SIGNED<br><u>6-10-55</u>                                                                                     |                                           |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>removal</u>                                                                                                                                                                                                        |                                  | 24b. DATE<br><u>6-10-55</u>                                                                    |                                                             | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Sikeston, Mo.</u>                                                                                                                                                                                                                                           |                                                                                   | 24d. LOCATION (City, town, or county) (State)<br><u>Sikeston, Mo.</u>                                                  |                                           |  |
| DATE REC'D BY LOCAL REG.<br><u>JUN 14 1955</u>                                                                                                                                                                                                                     |                                  | REGISTRAR'S SIGNATURE<br><u>J. Carl Smith</u>                                                  |                                                             | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Albritton, Sikeston, Mo.</u>                                                                                                                                                                                                                          |                                                                                   |                                                                                                                        |                                           |  |

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed *Bill C. Brown*

Licensed Embalmer No....4....

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.