

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25759

BIRTH NO. 49287-55 REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 144

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY MONTGOMERY	
b. CITY OR TOWN WASHINGTON		c. CITY OR TOWN	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St Francis Hosp		e. STREET ADDRESS (If rural, give location) 8 mile Northwest of Jonesburg	

3. NAME OF DECEASED (Type or Print) MARLENA BEKA LAMPE	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Aug 17 55
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Aug 12-55	9. AGE (In years last birthday) 8	UNDER 1 YEAR Months	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)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Herman MO	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Wm. F. Lampe	13b. MOTHER'S MAIDEN NAME CECILIA SCOTT	14. NAME OF HUSBAND OR WIFE
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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 Wm Lampe ADDRESS New Florence Mo
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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, assthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MENINGITIS, CEREBOSPINAL		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	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 **8-12**, 19**55** to **8-17**, 19**55**, that I last saw the deceased alive on **8-17**, 19**55**, and that death occurred **at 1:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) George M. Workman M.D.	23b. ADDRESS HERMANN, MO	23c. DATE SIGNED 8-17-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 19-55	24c. NAME OF CEMETERY OR CREMATORY Jonesburg	24d. LOCATION (City, town, or county) (State) Jonesburg MO
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DATE REC'D BY LOCAL REG. 8/19/55	REGISTRAR'S SIGNATURE F. C. Hedman	25. FUNERAL DIRECTOR'S SIGNATURE B. B. Dearing ADDRESS Jonesburg Mo
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(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.....
Signature of Student Embalmer

Signed *Carl A. Dauding*.....

Licensed Embalmer No. *411*.....

P. O. Address *Jonesboro*.....

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.