

FILED OCT 7 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30816

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 365

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Boone</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia,</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone Co. Hosp.</u>			Length of stay in lb <u>D.O.A.</u>	d. STREET ADDRESS <u>703 Clinkscale Rd.</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>William Harry Lamb</u>				First <u>William</u>	Middle <u>Harry</u>	Last <u>Lamb</u>	4. DATE OF DEATH Month <u>Oct.</u> Day <u>3,</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7, 1883</u>		9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Macon County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James Lamb</u>				14. MOTHER'S MAIDEN NAME <u>Bay Stokes</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>495-36-2108</u>	17. INFORMANT Address <u>Frank Lamb, Columbia, Mo.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH. <u>45 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) _____	
DUE TO (c) _____							PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>								
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____				
21. I attended the deceased from <u>Aug 7, 57</u> to <u>Oct 3, 57</u> and last saw <u>him</u> alive on <u>10-3-57</u> Death occurred at <u>12 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Name or title) <u>LeRoy Miller, M.D.</u>				22b. ADDRESS <u>22 N. 8th Columbia</u>		22c. DATE SIGNED <u>4 Oct. 57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/6/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Columbia</u>		23d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Lyman Sprinkle, Columbia, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Oct 4 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R. E. Palmer,</u>			

(Licensed Embalmer's Statement on Reverse Side)

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Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Lynna J. Sprinkle* .....

Licensed Embalmer No. *40*

P. O. Address *Columbus*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
(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.