

Health, Welfare  
Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 10 1957

31022

STATE FILE NUMBER

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 237

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lewis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton 2</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>LaGrange</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #1</b> Length of stay in lb <b>4 yr 5 mo</b>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PHIL</b> Middle <b>LAMBERT</b> Last <b>LAMBERT</b>		4. DATE OF DEATH Month <b>9</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Male 0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-1873</b>
9. AGE (In years last birthday) <b>83</b>		10. MONTHS <b>3</b>	11. DAYS <b>9</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fisherman, Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Quincy, Illinois /</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Unknown</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>State Hospital #1; Fulton, Missouri</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (a) <b>Generalized arteriosclerosis 10 yrs</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <b>Senility.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		332X	
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 _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <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. Attended the deceased from <b>State Hosp. #1</b> <b>5-5-1953</b> to <b>9-29-1957</b> and last saw her alive on <b>9-29-57</b> Death occurred at <b>1:15 p.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>C. Harold Dieren M.D.</b>	
22b. ADDRESS <b>State Hospital #1; Fulton, Mo.</b>		22c. DATE SIGNED <b>9-29-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>10/1/1957</b>		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) (State) <b>Columbia Mo.</b>	
24. FUNERAL DIRECTOR <b>W. E. Johnston</b> ADDRESS <b>Columbia Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Oct-1-1957</b>	
26. REGISTRAR'S SIGNATURE <b>Maretha Lawrence</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

**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 .....

Licensed Embalmer No.....  
P. O. Address.....

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.