

Health,  
Welfare  
Public  
Service

S. 300  
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

46833

STATE FILE NUMBER

FILED JAN 7 1958

Registration District No. 317 Primary Registration District No. 600 Registrar's No. 3239

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS,</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST LOUIS,</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FENTON</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>FENTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>FIESTER NURSING HOME</b> INSTITUTION <b>FENTON</b>		Length of stay in 1b <b>7 1/2 months</b>	d. STREET ADDRESS <b>FIESTER NURSING HOME</b> <b>FENTON</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CECELIA</b> First <b>LAMB</b> Last			4. DATE OF DEATH Month <b>DEC</b> Day <b>20,</b> Year <b>1957</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN, 1, 1867</b>	9. AGE (In years last birthday) <b>90</b> 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) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (City and state or country) <b>ST LOUIS MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>PATRICK HEFFERMAN</b>		13b. MOTHER'S MAIDEN NAME <b>MARY KELLY</b>		14. NAME OF HUSBAND OR WIFE <b>HUGH PATRICH LAMB</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give nature of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>SYLVIA WADICK 4884 PENROSE ST.</b>	
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 Vascular Accident</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Generalized Arterio-sclerosis.</b>					
DUE TO (c) <b>331X</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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. Month, Day, Year _____					
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. I attended the deceased from: <b>Nov. 15, 1957</b> to <b>Dec. 20 '57</b> and last saw her alive on <b>12/20/57</b> Death occurred at <b>6:45</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Frank Heck M.D.</b> (Degree or title)			22b. ADDRESS <b>Fenton, Mo.</b>		22c. DATE SIGNED <b>12/21/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>12/23/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ST LOUIS MISSOURI</b>
24. FUNERAL DIRECTOR <b>STROOT - CARROLL</b> ADDRESS <b>4600 NATURAL BRIDGE AVE</b>			25. DATE RECD. BY LOCAL REG. <b>12-23 57</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donkema</b>	

(Licensed Embalmer's Statement on Reverse Side)

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

*Ar. B. Buck*

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 *M. W. Rueter* .....

Licensed Embalmer No. *4865* .....  
P. O. Address *St. Louis, Mo.* .....

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.