

Health,  
Welfare  
Public  
vice

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 13 1958

2016

STATE FILE NUMBER

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 30

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Hannibal</b> 264 1/2 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Levering Hospital</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>704 Hickory</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Stella</b> Middle <b>Adeline</b> Last <b>Lambert</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>20</b> Year <b>1958</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-1903</b>	9. AGE (In years at birthday) <b>54</b>	FUNDER 1 YEAR Months Days	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) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Hannibal, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Scott McGlasson</b>	13b. MOTHER'S MAIDEN NAME <b>Lilly Mae Shinn</b>	14. NAME OF HUSBAND OR WIFE <b>Howard Lambert</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Howard Lambert</b>	Address <b>704 Hickory-Hannibal Missouri</b>
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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>myocardial, infarct, acute</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) _____ DUE TO (c) _____		
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 checked="" type="checkbox"/> NO <input 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.)
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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 <b>Hannibal</b>	COUNTY <b>Marion</b>	STATE <b>Missouri</b>
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21. I attended the deceased from Death occurred at <b>Jan. 20, 1958</b> to <b>Jan. 20, 1958</b> and last saw her alive on <b>decd 1/20/58</b> <b>5:25 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Robert J. Lanning, M.D.</b>	(Deed or title)	22b. ADDRESS <b>Hannibal, Mo</b>	22c. DATE SIGNED <b>1/20/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/20/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grand View Burial Park</b>	23d. LOCATION (City, town, or county) <b>Hannibal, Missouri</b>	(State)
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24. FUNERAL DIRECTOR <b>H.M.O'Donnell-Hannibal, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>2/5/58</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E.M. Luke By H.O. Fisher</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms were observed. All diseases in Part I must be causally related.

RECEIVED FEB 10 1958  
MARION CO. HEALTH DEPT.  
DATE FILED FEB 10 1958

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 W. M. McDonnell .....

Licensed Embalmer No. 3889 .....

P. O. Address Hannibal, 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.