

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005059
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 50

300
-57 C

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON		c. CITY OR TOWN UNION	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSP.		d. STREET ADDRESS (If outside, give location) 200 WALLEY AVE.	

3. NAME OF DECEASED (Type or print) First LOUISA Middle J. Last LAMBETH			4. DATE OF DEATH Month FEB. Day 14, Year 1959		
-------------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------------------	--	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 17, 1884	9. AGE (In years at birthday) 74	IF UNDER 1 YEAR Months 8 Days 27	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------	--------------------------------------------	---------------------------------------------------	------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (City and state or country) VILLA RIDGE, MO.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---------------------------------------------------------------------------------------------	-------------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------

13a. FATHER'S NAME JAMES HARVEY TRIPLETT	13b. MOTHER'S MAIDEN NAME ANNIE ELLETT	14. NAME OF HUSBAND OR WIFE JOSEPH LAMBETH
----------------------------------------------------	--------------------------------------------------	------------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address MRS. JAMES OSBORN PACIFIC, MO.
------------------------------------------------------------------------------------------------------------------------	----------------------------------------	----------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a)-(b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral fibrillation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>195</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Arteriosclerotic cardiovascular dis.</i>	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Multiple pulmonary emboli</i>		19. WAS AUTOPSY PERFORMED? 1 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.) <i>Asphyxiation</i>
-----------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ 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 <i>Nov. 1957</i> to <i>Feb 1959</i> and last saw her alive on <i>2/14/59</i> Death occurred at <i>10:00 PM</i> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) <i>Louis J. Lambeth</i>	22b. ADDRESS <i>Union Mo</i>	22c. DATE SIGNED <i>2/16/59</i>
-----------------------------------------------------------	---------------------------------	------------------------------------

23a. BURIAL, CREMATION, or other (Specify) BURIAL	23b. DATE 2-17-59	23c. NAME OF CEMETERY OR CREMATORY BRUSH CREEK CEMETERY	23d. LOCATION (City, town, or county) (State) GRAY SUMMIT, MO.
-------------------------------------------------------------	-----------------------------	-------------------------------------------------------------------	--------------------------------------------------------------------------

24. FUNERAL DIRECTOR ADDRESS OLTMANN FUNERAL HOME UNION, MO.	25. DATE RECD. BY LOCAL REG. <i>2/17/59</i>	26. REGISTRAR'S SIGNATURE <i>H. P. ...</i>
------------------------------------------------------------------------	------------------------------------------------	-----------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

YS DEC 9 1959

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 *Ralph Altman*

Licensed Embalmer No. *4808*

P. O. Address *Union, 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.