

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019367
STATE FILE NUMBER

FILED JUN 4 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. 4972

300
-57

74

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PARK LANE HOSP.		d. STREET ADDRESS (If outside, give location) 1037 PARK	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES BENJAMIN LAMB		4. DATE OF DEATH Month Day Year MAY 21, 1959	
5. SEX MALE	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 FEB. 21, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS	11. BIRTHPLACE (City and state or country) ARKANSAS
13a. FATHER'S NAME TOM LAMB		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE MARGARET LAMB
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no <input checked="" type="checkbox"/> unknown) (If yes, give name and dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address MARGARET LAMB MANILA, ARKANSAS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic injuries including multiple rib fractures with anterior depression of thorax. DUE TO (b) Recent Coronary Occlusion. DUE TO (c) Suffered when car operated PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Suffered when car operated			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 65 W. Hwy #67 near Fredericktown, Mo.		
20c. TIME OF INJURY Hour Month, Day, Year 5 15 PM May 15, 1959	20f. CITY, TOWN, OR LOCATION COUNTY STATE near Fredericktown Mo		
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul J. Simon		22b. ADDRESS 1300 Clark	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23c. NAME OF CEMETERY OR CREMATORY OAKLAWN	
23b. DATE 5/25/59		23d. LOCATION (City, town, or county) (State) JONESBORO, ARKANSAS	
24. FUNERAL DIRECTOR Howard Funeral Home - Blethen, Ark.		25. DATE RECD. BY LOCAL REG. 5-22-1959	
26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

mgs

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 *Paul R. Paul*

Licensed Embalmer No. *3481*
P. O. Address *Crystal*

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.