

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028544

FILED VS SEP 2 1959 88

Registration District No. Primary Registration District No. 5325 Registrar's No. 33

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CRAWFORD</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COURTOISE TOWNSHIP</u>		Length of stay in lb <u>82 yrs.</u>		c. CITY OR TOWN <u>COURTOISE TOWNSHIP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>14 MILE - STEELVILLE, MO.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>14 MILE - STEELVILLE, MO.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DORA ISABELLE LAMBERT</u>				4. DATE OF DEATH Month Day Year <u>AUG. 19 - 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1877</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>CRAWFORD Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>JOHN WESLEY LAMBERT</u>		13b. MOTHER'S MAIDEN NAME <u>CORNELIA DOBKINS</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CLIFFORD LAMBERT - STEELVILLE, MO.</u> 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) <u>Shock & Sepsis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fracture of femur. Surgical neck</u> DUE TO (c) <u>Fall and old age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Age</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT <input checked="" 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.) <u>Fall on linoleum cov. floor</u>			
20c. TIME OF INJURY Hour a.m. p.m. <u>—</u>		Month, Day, Year <u>—</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Rural</u>		COUNTY <u>Crawford</u>		STATE <u>Mo</u>	
21. I attended the deceased from <u>Date of injury to death</u> and last saw her alive on <u>Aug 17th 1959</u> Death occurred at <u>4:20 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) <u>W. E. G. Beatty M.D.</u>			
22b. ADDRESS <u>St. James, Mo</u>				22c. DATE SIGNED <u>8-22-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8-21-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DOBKINS CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CRAWFORD Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>Thomas & Helen</u>		ADDRESS <u>STEELVILLE, MO.</u>		25. DATE REC'D. BY LOCAL REG. <u>8/29/59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Hazel Lichner</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Thomas S. Halbert

Licensed Embalmer No. 4332

P. O. Address STEELVILLE, I

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.