

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003688

FILED VS JAN 22 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 488** STATE FILE NUMBER

| | | | | | |
|--|--|---|--|--|---|
| 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 | | Length of stay in 1b 40 Yrs. | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1418 Mississippi | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|------------------------------|---|---|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Oca Middle Lambert Last Lambert | | | 4. DATE OF DEATH Month 1 Day 13 Year 60 | | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 6/10/01 | 9. AGE (last birthday) 58 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) Bonne Terre, Mo | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME Clark Jackson | | | 13b. MOTHER'S MAIDEN NAME Elizabeth Caldwell | | 14. NAME OF HUSBAND OR WIFE Feron Lambert | | |
| 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. Unknøwn | 17. INFORMANT Address Feron Lambert, 1418 Mississippi | | | |

| | | | | | | | |
|---|------------|---------------------------------------|--|--|---|----------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Heart Bloed. | | | | | | 1 week | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | Arteriosclerotic Heart Disease | | | | year | |
| | DUE TO (c) | Coronary Infarction. Suspect | | | | 1 week | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus. 4200 | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | |

| | | | | | | | |
|--|---|---|--|------------------------------|--|--------|-------|
| 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.) 4200 | | | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year | | | | | | |
| 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 **1957** to **1960** and last saw ^{her} **alive on 1/17/60** _{her} **ya**
Death occurred at **1/13/60 6:20 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | | | |
|---|-----------------------------|--|---|--|------------------------------------|--|
| 22a. SIGNATURE Shaver Friedman MD | | (Degree or title) | 22b. ADDRESS 607 No Grand Blvd. | | 22c. DATE SIGNED 1/18/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 1-16-60 | 23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cem | | 23d. LOCATION (City, town, or county) St. Louis Co., Mo. | | |

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|--|--|---------|--|--|--|--|
| 24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette, (4) | | ADDRESS | 25. DATE REGD. BY LOCAL REG. JAN 14 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | |
|--|--|---------|--|--|--|--|

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

H. G. Farris

Licensed Embalmer No.

3384

P. O. Address

St. Louis

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.