

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021182

FILED VS. MAY 18 1960

318

Primary Registration District No.

1003

Registrar's No.

4851

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		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 Home Of The Friendless			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4431 So. Broadway		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Ruth Last Lambert				4. DATE OF DEATH Month May Day 6 Year 1960				
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/12/1879	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (City and state or country) Irvington, Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Nellie B. Lambert			13b. MOTHER'S MAIDEN NAME Elizabeth Huggins			14. NAME OF HUSBAND OR WIFE Never married		
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. 490-18-9452		17. INFORMANT Address Home Of The Friendless 4431 So. Broadway			
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)			Cerebral Hemorrhage				2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) Generalized Arteriosclerosis				Several months	
DUE TO (c)			331x					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 type="checkbox"/> NO <input checked="" 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.)				
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 April 1959 to May 6, 1960 and last saw her ^{her} him alive on May 4, 1960 Death occurred at 9:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Keypine N. Chaskey, M.D.				22b. ADDRESS 3720 Washington - St. Louis		22c. DATE SIGNED May 7, 1960		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/9/60	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) Lemay, Mo.			(State)
24. FUNERAL DIRECTOR Hofmeister Colonial Mortuary ADDRESS 6464 Chippewa St. St. Louis, Mo.				25. DATE RECD. BY LOCAL REG. MAY 9 1960		26. REGISTRAR'S SIGNATURE Loed Smith, M.D.		

(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 Bill C. Brown

Licensed Embalmer No. 476

P. O. Address St. Louis

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