

FEDERAL BUREAU OF INVESTIGATION
DEPARTMENT OF JUSTICE
UNITED STATES GOVERNMENT

-60-039921

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10018**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
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 St. Louis - Little Rock Hospitals Inc.		d. STREET ADDRESS 3626 A Humphrey	

3. NAME OF DECEASED (Type or print) First Elvena Middle B Last Lamb	4. DATE OF DEATH Month October Day 15 Year 1960
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-2-1891	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME JAMES SWINEY	13b. MOTHER'S MAIDEN NAME LUCY COPELAND	14. NAME OF HUSBAND OR WIFE J.H. LAMB (DECD)
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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.	17. INFORMANT Address Rev. James Lamb 1284 Chambers Rd.
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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) Acute MYOCARDIAL INFARCTION		9 DAYS
DUE TO (b) CORONARY THROMBOSIS		"
DUE TO (c) Hypertensive & Arteriosclerotic Heart Dis.		2 Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201	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
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19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	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.)
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20c. TIME OF INJURY Hour 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
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21. I attended the deceased from 1958 to 10-15-60 and last saw her alive on Oct 14, 1960 Death occurred at 3.45 A. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Jhva Carrier, MD (Degree or title)	22b. ADDRESS 1755 S. Grand Blvd	22c. DATE SIGNED 10-15-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE OCT 17, 1960	23c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR ADDRESS Kutis Funeral Home 2906 Gravois	25. DATE RECD. BY LOCAL REG. OCT 17 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 7906 Jra

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.