

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013371

MENT OF PUBLIC HEALTH AND WELFARE

DR. LURIE

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

FILED MAY 8 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE IOWA b. COUNTY Clinton				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in lb 3 DAYS		c. CITY OR TOWN CLINTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1109 S. 9th ST.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EARL B. LAMBERT				4. DATE OF DEATH Month Day Year APRIL 28 1961				
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 10/7/86		
9. AGE (last birthday) 74		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) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY CIVIL ENGINEER		11. BIRTHPLACE (City and state or country) NEWTON, IOWA		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME ELLIOTT E. LAMBERT			13b. MOTHER'S MAIDEN NAME MARY BOYDSTON			14. NAME OF HUSBAND OR WIFE CYNTHIA 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. 478-10-7160		17. INFORMANT Address DR. WM. C. FRANCIS, SPRINGFIELD MO.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure Rheumatic Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ? DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 1 week	
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 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.)				
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 4/25/61 to 4/28/61 and last saw him alive on 4/28/61 Death occurred at 3:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Please or title) Harold H. Lurie M.D.				22b. ADDRESS 600 S. Hendstone Springfield, Mo.		22c. DATE SIGNED 4/28/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 4/29/61		23c. NAME OF CEMETERY OR CREMATORY NEWTON UNION CEM.		23d. LOCATION (City, town, or county) (State) NEWTON, IOWA		
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.				25. DATE RECD. BY LOCAL REG. 5-1-61		26. REGISTRAR'S SIGNATURE Effie S. Melton		

1961 6 T NNC

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 RL Mc Conn

Licensed Embalmer No. 2727

P. O. Address Spokane, WA

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.