

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6209-61-044834  
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. \_\_\_\_\_

FILED DEC 22 1961

DATE AMENDED: 2/13/62, 2/13/62  
INSTEAD OF: Unknown No  
DOCUMENT: James W. Fowle MEDICAL CERTIFICATION  
SHOULD READ: 498-38-8509  
BY AFFIDAVIT OF Informant: Yes, June 1957 - June 1959

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Boon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City, Mo.</b>		Length of stay in 1b <b>10 Weeks</b>	c. CITY OR TOWN <b>Columbia, Missouri</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Luth. Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1005 East Rollins</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Donald William Lamb</b>			4. DATE OF DEATH Month Day Year <b>Dec. 9 1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-34</b>
9. AGE (last birthday) <b>27 Yrs.</b>		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State University</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>Waldo V. Lamb</b>	
13b. MOTHER'S MAIDEN NAME <b>Lois Brandon</b>		14. NAME OF HUSBAND OR WIFE <b>Norma Watkins Lamb</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No Yes June, 57 to June, 59 unknown</b>		16. 17. INFORMANT Address <b>Lois Lamb Fayette, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL BRONCHIAL PNEUMONIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b>
DUE TO (b) <b>MALIGNANT LYMPHOBLASTIC LYMPHOMA &amp; LEUKEMIA</b>			<b>2 YRS</b>
DUE TO (c) _____			
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 <b>JAN 1960</b> to <b>DEC 9, 1961</b> and last saw <sup>him</sup> alive on <b>DEC 8, 1961</b> Death occurred at <b>8:30 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>James W. Fowler, M.D.</b>		22b. ADDRESS <b>1103 GRAND AVE</b>	22c. DATE SIGNED <b>12-9-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-9-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elliott Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Brunswick, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>WAGNER FUNERAL HOME, K. C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-10-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

**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 A. R. Hauschild

Licensed Embalmer No. 4159

P. O. Address Kansas City

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.