

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032631
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7735**

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. FILED AUG 31 1962		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St. Louis		a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If outside, give location) 1418 Mississippi Reside on Farm Yes ☐ No ☒	
3. NAME OF DECEASED (Type or print) First Frances Middle Lambert Last		4. DATE OF DEATH Month August Day 5 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH 5-12-1876
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) Louisville, Ky.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Perkins		13b. MOTHER'S MAIDEN NAME Mary Unknown	
14. NAME OF HUSBAND OR WIFE Unknown deceased		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. None		17. INFORMANT Calvin Lambert Address 2847 Chippewa	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease, Generalized atherosclerosis. Fracture of left femur DUE TO suppressed in fall at her home on July 28, 1962 DUE TO accident 7:00 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (b) See above			
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒		20a. ACCIDENT SUICIDE HOMICIDE ☒ ☐ ☐	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See above		20c. TIME OF INJURY Hour 7-28-62 a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 23 Home	
20f. CITY, TOWN, OR LOCATION St. Louis, Mo		COUNTY STATE	
21. I attended the deceased from 7:00 P. to her and last saw him alive on him Death occurred at 7:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Walter L. Taylor, Coroner		22b. ADDRESS 1300 Clark Ave	
22c. DATE SIGNED 8-8-62		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE August 8, 62		23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	
23d. LOCATION (City, town, or county) St. Louis, Missouri		23e. DATE RECD. BY LOCAL REG. AUG 8 1962	
23f. REGISTRAR'S SIGNATURE Loal Smith. M.D.		23g. REGISTRAR'S SIGNATURE	

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.