

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-037342

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 217

FILED OCT 15 1962

VS 300	DATE AMENDED
Rev. 4/59	
11007	DATE AMENDED
21007	
3	DATE AMENDED
4 1	
5 1	DATE AMENDED
6	
7 1	DATE AMENDED
8 2	
94200	DATE AMENDED
10	
11	DATE AMENDED
12 1-0	
13 2-0	DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTON</u>		Length of stay in 1b <u>4 DAYS</u>	c. CITY OR TOWN <u>SIKESTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MO DELTA COMMUNITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>219 DOROTHY ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>AUTIE ETHEL LAMBERT</u>			4. DATE OF DEATH Month Day Year <u>OCTOBER 9, 1962</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE (last birthday) <u>74</u> IF UNDER 1 YEAR Months Days Hours Min. <u>3 4</u>
11a. FATHER'S NAME <u>JOHN A. NELSON</u>		11b. MOTHER'S MAIDEN NAME <u>NANNIE HAWKINS</u>	11c. NAME OF HUSBAND OR WIFE <u>C. W. LAMBERT</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MRS. W.M. JONES, SIKESTON, MO.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>at once</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Advanced Arteriosclerotic Heart Disease</u>			<u>10 years</u>
DUE TO (c) <u>Decompensation with aneurysm</u>			<u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <u>-</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown <input type="checkbox"/>
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.) <u>-</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>-</u>			
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.) <u>-</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>-</u>
21. I attended the deceased from <u>1952</u> to <u>9-Oct-62</u> and last saw her <u>live</u> on <u>10-9-62</u> Death occurred at <u>4:25 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. B. Thompson M.D.</u>		22b. ADDRESS <u>Sikeston, MO</u>	22c. DATE SIGNED <u>9 Oct-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-12-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF MEMORIES</u>	23d. LOCATION (City, town, or county) (State) <u>SIKESTON Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>MUNNIE FUNERAL CHAPEL, SIKESTON, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 11 - 1962</u>	26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>

USE BLACK INK OR TYPEWRITER RIBBON

OCT 17 1962

Permit issued Oct 10 - 1962

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 Edward E. Hummel

Licensed Embalmer No. 4164

P. O. Address Sikeston, Mo.

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.