

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039847

STATE FILE NUMBER

Registration District No. 4948 Primary Registration District No. 6024 Registrar's No. 115

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 16 1962

1. PLACE OF DEATH a. COUNTY <b>Ray</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Ray</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Polk</b>		c. CITY OR TOWN <b>Miles East of Lawson</b>	
Length of stay in 1b <b>10 Years</b>		Inside Limits <b>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7 Miles East of Lawson</b>		d. STREET ADDRESS (If outside, give location)	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm <b>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></b>	

3. NAME OF DECEASED (Type or print) First <b>Everett</b> Middle <b>Ernest</b> Last <b>Lamb</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>8</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-24-1911</b>	9. AGE (last birthday) <b>51</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Lawson Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Albert Lamb</b>		13b. MOTHER'S MAIDEN NAME <b>Lieucretia Clevenger</b>		14. NAME OF HUSBAND OR WIFE <b>Never Married</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War 2</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mabel Denton, Lawson, Missouri</b>

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>ANOXIA</b>		
DUE TO (b) <b>CARDIAC STANDSTILL</b>		
DUE TO (c) <b>MASSIVE CORONARY OCCLUSION</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>A.S.H.D. &amp; HISTORY OF 3-4 PREVIOUS INFARCTIONS</b>		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
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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.)	
20c. TIME OF INJURY Hour <b>8:55</b> a.m. / p.m.			
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 **12-3-60** to **10-8-62** and last saw <sup>him</sup> ~~her~~ alive on **10-2-62**  
Death occurred at **8:55 a** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>A. J. Pfauth, D.O.</b>	22b. ADDRESS <b>LAWSON, MO</b>	22c. DATE SIGNED <b>10-19-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/10/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lawson</b>	23d. LOCATION (City, town, or county) (State) <b>Lawson, Missouri</b>
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24. FUNERAL DIRECTOR <b>Jarman Funeral Home, Lawson, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-12-1962</b>	26. REGISTRAR'S SIGNATURE <b>Mabel Jackson</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

VS 300 Rev. 4/59  
**10890**  
**20890**  
3  
4 **0**  
5 **0**  
6  
7 **0**  
8 **2**  
**94200**  
10  
11  
12 **90-2**  
13 **2-0**

OCT 19 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

*Ralph Van Landingham*

Licensed Embalmer No. 4009

City of Address Chickin Springs, MD

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.