

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

15157 **14890**

**1. PLACE OF DEATH**

County.....  
Township.....  
City 3936 N. 9 St.

Registration District No. 791  
Primary Registration District No. 1003

File No. ....  
Registered No. 4082  
St. (.....) Ward (.....)

**2. FULL NAME**

Irving Lohambulin

(a) Residence. No. 3936 N. 9 St. 16 Ward.

(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF married

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
abt. 34 — —

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Watchman  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... St. Louis Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... " " (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... " " (STATE OR COUNTRY)

14. INFORMANT (Address) Joseph Mogha 3936 N. 9

15. FILED 14 1928 Max O. Starck REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 13, 1928

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., and that I last saw him..... alive on..... 19....., and that death occurred, on the date stated above, at 9 a m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chronic Endocarditis  
92 yrs. mos. da.

CONTRIBUTORY (SECONDARY) 900 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED.....  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....  
(Signed) Wm. Dwyer M.D.  
4/15, 1928 (Address) Dep. Coroner

\*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Friends DATE OF BURIAL April 16, 1928

20. UNDERTAKER Shedmyer ADDRESS 3934 N. 20

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

