

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

Do not use this space.

16418

File No. 1104
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 125
Township Cape Girardeau Primary Registration District No. 3009
City Cape Girardeau

2. FULL NAME

(a) Residence No. 923 North Santa Ward _____
(Usual place of abode)

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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Rosa L. Lehne

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 30th 1861

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>67</u>	<u>8</u>	<u>6</u>	<u>6</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Egypt Mills
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER M. August Lehne

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

12. MAIDEN NAME OF MOTHER Mrs. Christiana

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

14. INFORMANT Mrs. Ann Lehne
(Address) 923 North Santa

15. FILED 5717 1928 W. Haueppfer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 1928

17. I HEREBY CERTIFY, That I attended deceased from 5-9 1928, to 5-15 1928
that I last saw h. alive on 5-15 1928, and that death occurred, on the date stated above, at 9:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

LOBAR PNEUMONIA (Rgt)
108

(duration) yrs. mos. da. 9 ds.

CONTRIBUTORY (SECONDARY) NONE
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 101A
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) A. Smith, M. D.

, 19 (Address) Rose Grandview

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 Fairview Cemetery DATE OF BURIAL May 11 1928

20. URBERTAKER Al. Bunker ADDRESS 536 Brook

N. B.—Every item of information applicable to the CAUSE OF DEATH in plain terms, so that it may be properly classified, is very important.

66-7-13

JUL

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Pope Registration District No. 123
 Township _____ Primary Registration District No. 3009
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Mr August Lehue
 (a) Residence. No. _____ St. _____ 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. 1104
 Registered No. _____
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 30 - 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 * 7 * 15 *

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

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.
 _____ (duration) yrs. mos. ds.

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) _____, M. D.
 _____, 19____ (Address)

*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.

14. INFORMANT _____ (Address) _____

15. FILED 7/19 28 W. H. Kump REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRATION should be carried out EXACTLY. PHYSICIAN should be carefully supplied. Exact statement of OCCUPATION should be given. Exact statement of CAUSE OF DEATH is very important. RECEIVED A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. N. B. - CAUSE OF DEATH

