

JAN 25 1920

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

Do not use this space.

1. PLACE OF DEATH

County *Morgan*
Township *Hay Creek*
City *Stover*

Registration District No. *919*
Primary Registration District No. *4551*

File No. *41795*
Registered No. *53*
St. _____ Ward _____

2. FULL NAME *Mrs Margaretha Lambke*

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Henry J Lambke*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 20 1852*

7. AGE YEARS MONTHS DAYS
76 1 28
If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Housewife*
(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) *Denton Co Mo*

10. NAME OF FATHER *Frederick Brauer*

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

12. MAIDEN NAME OF MOTHER *Brockman*

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

14. INFORMANT *Geo M Lambke*
(Address) *Stover Mo*

15. FILED *Jan 10th 1920*
Wm Rippinger
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 18 1928*

17. I HEREBY CERTIFY That I attended deceased from *Dec 12* to *Dec 18 1928*
that I last saw him alive on *Dec 17 1928*, and that death occurred, on the date stated above, at *12 1/2* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia

CONTRIBUTORY (SECONDARY) *10/10*
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

19. WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Chas A West*, M. D.

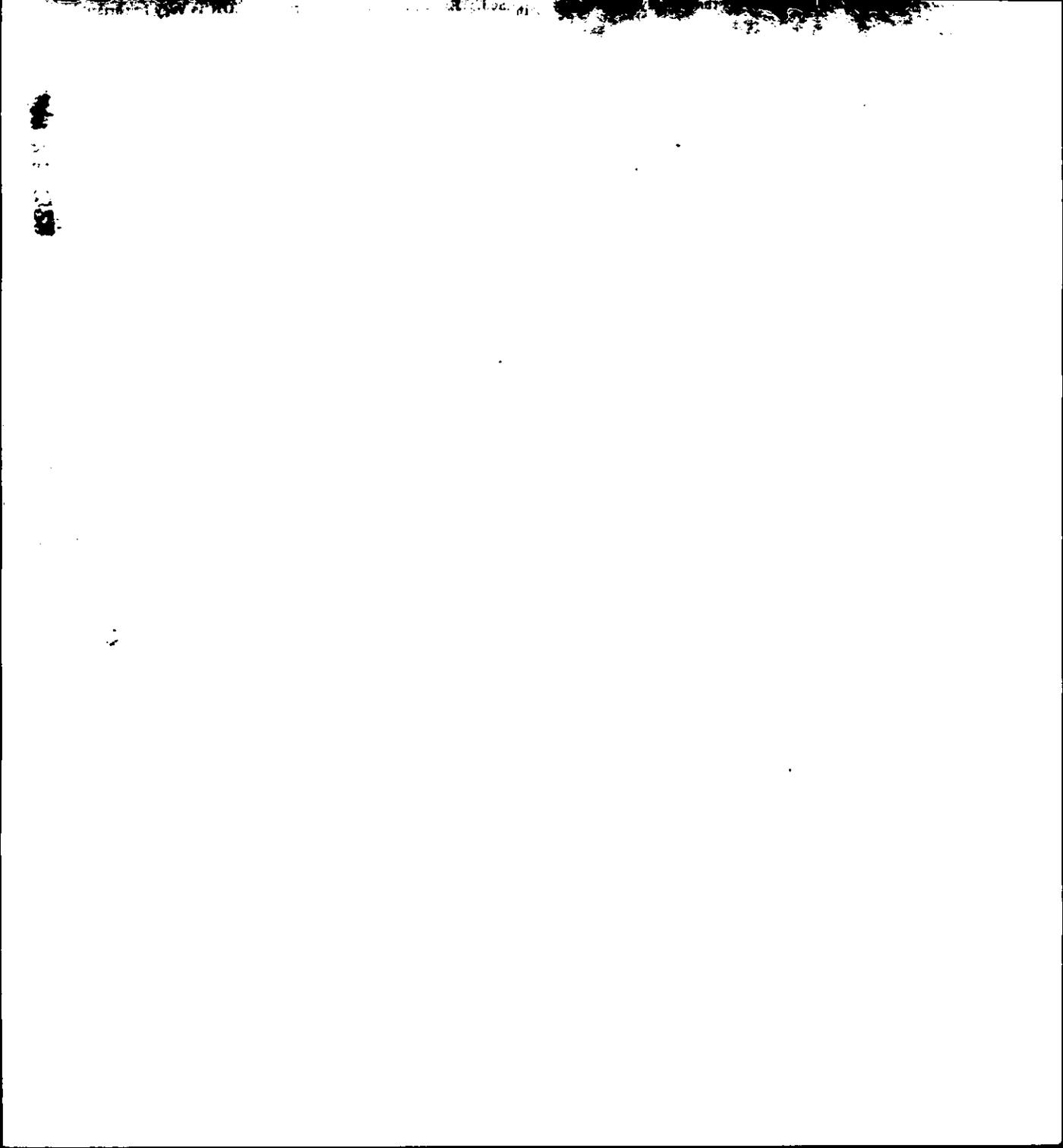
Dec 19, 1928 (Address) *Stover Mo*

*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 *Stover Cemetery* DATE OF BURIAL *Dec 19 1928*

20. UNDERTAKER *O. R. Kapp* ADDRESS *Stover Mo*

Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Morgan Registration District No. 919 File No.
 Township Primary Registration District No. 4551 Registered No. 55
 City Stover (No.) St. Ward (.....)

2. FULL NAME

Margartha Tambke
 (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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/20/1952

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hra. ormin.
	<u>76</u>	<u>1</u>	<u>28</u>	

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)

PARENTS

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) unknown
 (STATE OR COUNTRY) Germany

14. INFORMANT
 (Address)

15. Jawiana 29 Thud Ripberger
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY That I attended deceased from
 19..... to 19.....
 that I last saw h..... 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.

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.

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

19

20. UNDERTAKER ADDRESS

CAUSE OF DEATH, and terms, etc. If it is to be printed, insert statement of OCCUPATION, etc. SEE IF ES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW REGISTRARS

SUPPLEMENTARY

5-41795