

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

Do not use this space.

13824

1. PLACE OF DEATH
 County Bollinger Registration District No. 67 File No. _____
 Township Frank Primary Registration District No. 5102 e Registered No. 19
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Mary Caroline Subbers
 (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 Female 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 Frank Subbers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 1 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 8 17

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) Bollinger Co Mo

10. NAME OF FATHER Thos. Eldricher

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

12. MAIDEN NAME OF MOTHER Mary Kewenig

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

14. INFORMANT Frank Subbers
 (Address)

15. FILED 4-9-29 R. Sander REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-9-1929

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 _____ m.

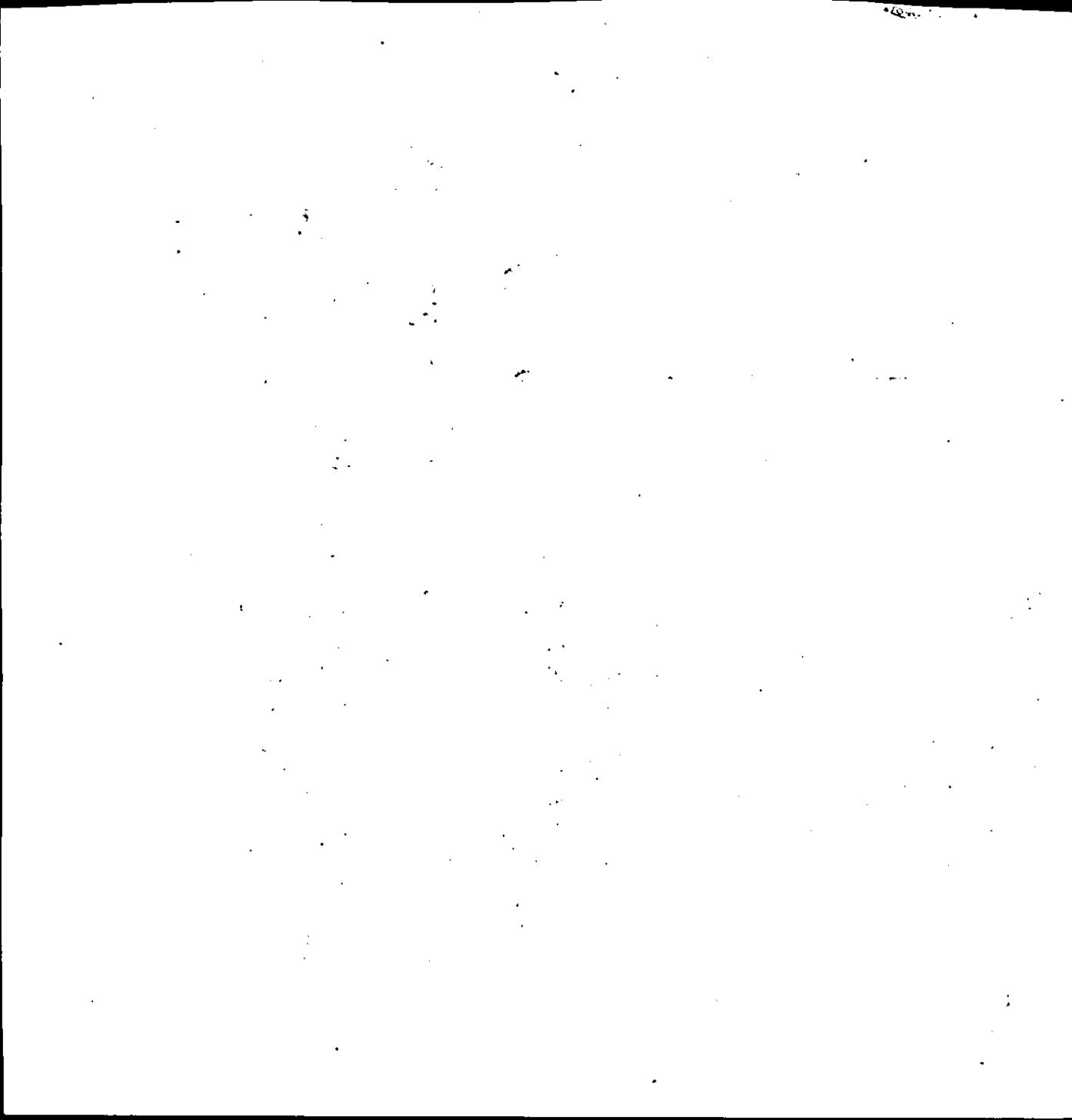
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Metral Arrhythmia
Complicated with Chronic
Interstitial Nephritis and
High Blood Pressure 2 yrs. mos. ds.
 CONTRIBUTORY Cardiac Arrhythmia Relayed Myocardial Infarction (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at place of death
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Physcal Examination
 (Signed) F. M. Shumey, M. D.
 , 19____ (Address) Paris 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 Leopold. Mo DATE OF BURIAL 9-1-1929

20. UNDERTAKER R. J. Baker ADDRESS Littonville



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Douglas
Township Lorraine
City (No. St. Ward)

Registration District No. 67
Primary Registration District No. 5702 c

File No.
Registered No. 19

2. FULL NAME

Mary Caroline Lubbers

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

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) (STATE OR COUNTRY)

14. INFORMANT (Address)
15. FILED 4-9, 1929 Chandler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-9 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.
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
20. UNDERTAKER Dr. B. Leopold M.D. 4-11 1929
G. J. Bunker ADDRESS Lutesville

SUPPLEMENTARY

REVIS: SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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