

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

Do not use this space.

19849

File No. 5464
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. 791
Township _____ Primary Registration District No. 1003
City St. Louis (No. 586.3a) Romane pl.

2. FULL NAME

(a) Residence No. _____ St. 5 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 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 Mary Clara, Lobourn

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 22, 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 1 24

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Virginia

10. NAME OF FATHER

William Lobourn

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER

Judy Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Virginia

14.

INFORMANT Mary L. Lobourn
(Address) 586.3a Romane

15.

FILED MAY 17 1929 May C. Staley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 16 1929

17. I HEREBY CERTIFY, That I attended deceased from _____
to _____, 1929, to _____, 1929,
that I last saw him alive on May 15, 1929, and that
death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Bronchopneumonia, Refractory
131
132 (6) (duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) weakened

(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) J. G. Fisher M. D.

. 1929 (Address) 5988 E. Cotton Ave

*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

Bellefontaine DATE OF BURIAL 5/18 1929

20. UNDERTAKER H. B. Berger ADDRESS 4715 McPherson

WRITE MAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

5788a East 76

2533

2222

