

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

Do not use this space.

30562

1. PLACE OF DEATH

County Greene Registration District No. 318
 Township _____ Primary Registration District No. 2001
 City Springfield (No. 2001) Boonville ave

File No. _____
 Registered No. 632
 St. _____ Ward _____

2. FULL NAME

Harry S. Lanenberg.
 (a) Residence, No. 1300ville (200 Black) rd.
 (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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** married (write the word)

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

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

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
about 65

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Leo Lanenberg.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) New York
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Marilla Duff

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
 (STATE OR COUNTRY) _____

14. INFORMANT Harry Lanenberg
 (Address) Memphis Tenn

15. FILED 9-13-29 For Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 9 19 29

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
 that I last saw him alive on Sept 10 1929, and that death occurred, on the date stated above, at _____, _____, _____, Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Amputation of heart
Rupture into esophagus
415
10 hrs (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Hemorrhage
 (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Wm C Stone M. D.

Sept 13, 1929 (Address) Springfield, 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 _____ **DATE OF BURIAL** _____

Memphis Tenn Sept 14 1929

20. UNDERTAKER _____ **ADDRESS** _____

Alma Lohmeyer Springfield

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.

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