

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

Do not use this space.

31385

ST 24 1929

1. PLACE OF DEATH

County Mississippi
Township Trapp
City Chafflestone

Registration District No. 566
Primary Registration District No. 3030

File No. _____
Registered No. 93
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Sarah Lumbach St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 83 yrs. 6 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>William T. Lumbach</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>March 31 1842</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>87</u>	<u>5</u>	<u>20</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
(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)

not known
Kentucky

10. NAME OF FATHER

Hill Griffith

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

not known
Kentucky

12. MAIDEN NAME OF MOTHER

Leah Griffith

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

not known
Kentucky

14. INFORMANT (Address)

Hill Griffith

15. Sept 21 - 1929

J. S. Vernon
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 1929

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to Sept 21 1929 that I last saw h.e.r. alive on Sept 10, 1929, and that death occurred, on the date stated above, at 4:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

11 B
110 A
4:20
(duration) yrs. mos. 17 ds.
CONTRIBUTORY Senility - Cholelithiasis
(SECONDARY)
Ca. stomach (duration) ? yrs. 2 mos. 20 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms

(Signed) E. Ches. Koberling M. D.

, 19 (Address) Charleston 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

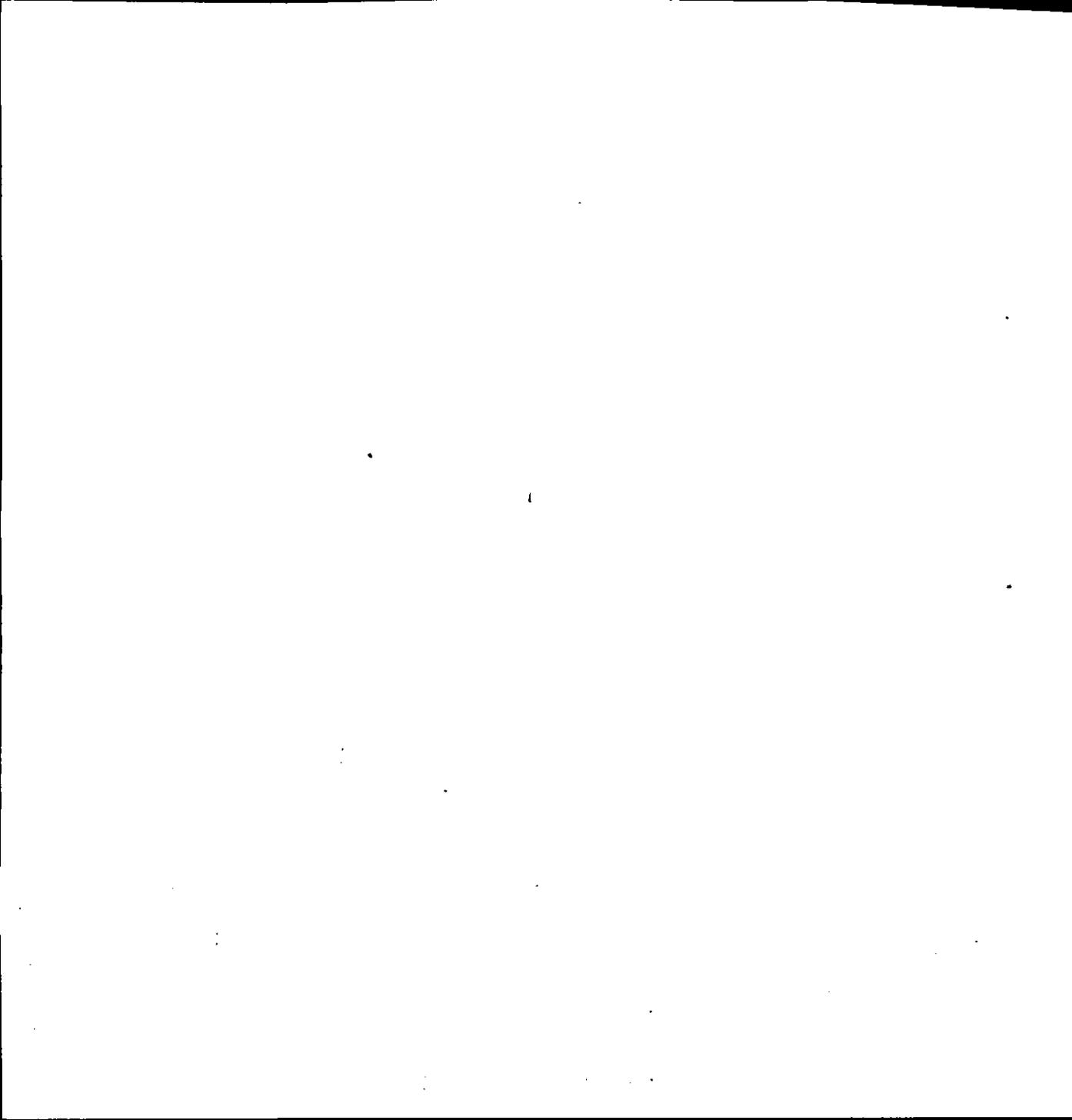
Oak Grove Cemet.

DATE OF BURIAL

9/22 1929

20. UNDERTAKER

ADDRESS



**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 Mississippi Registration District No. 366 File No. _____
 Township Charleston Primary Registration District No. 3030 Registered No. 93
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Sarah Lumback
 (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) Wid

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 _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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) _____

14. INFORMANT _____ (Address) _____

15. FILED Nov 8th 29 F. S. Verum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 1929

17. I HEREBY CERTIFY That I attended deceased from _____ 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:

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

CONTRIBUTORY (SECONDARY)

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, HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____

DATE OF BURIAL _____

20. UNDERTAKER _____

ADDRESS _____

Sari and Co Charleston Mo

SUPPLEMENTARY

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

5-31-35