

WRITE PLAINLY, 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.

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

Do not use this space.

**1. PLACE OF DEATH**

County Bates Registration District No. 47 File No. 28255  
 Township Mound Primary Registration District No. 5071 Registered No. \_\_\_\_\_  
 City Adrian (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Andrew Clinton Lombert

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 18 - 1913

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
21 6 25

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Printer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) King City Missouri

13. NAME A. J. Lombert

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) King City Mo.

15. MAIDEN NAME Aronna McAllister

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) King City Mo.

17. INFORMANT (ADDRESS) A. J. Lombert Adrian Mo.

18. BURIAL, CREMATION OR REMOVAL PLACE Crest Hill DATE Aug 15 1934

19. UNDERTAKER (ADDRESS) Creath & S. Co. Adrian Mo.

20. FILED Sept 10 1934 Miss Pearl C. Perry Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 13 1934

22. I HEREBY CERTIFY, That I attended deceased from Aug 12 1934 to Aug 13 1934

I last saw him alive on Aug 12 1934 Death is said to have occurred on the date stated above, at 12:40 m.

The principal cause of death and related causes of importance were as follows:

Tubercular Spinal Meningitis  
 Other contributory causes of importance: \_\_\_\_\_  
 Date of onset: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) E. C. Robinson, M. D.

(Address) Adrian, Mo.

