

43153

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 20 1941
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 542

Primary Registration District No. 5731

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Monroe Co.
(b) City or town Carrollton
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Monroe
(c) City or town Carrollton Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Jerome Steve Lubbert

3. (b) If veteran, name war _____ 3. (c) Social Security No. No

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Oct. 3 1920
(Month) (Day) (Year)

8. AGE: Years 15 Months 7 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Monroe Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation farm boy

11. Industry or business _____

12. Name James Conrad Lubbert
13. Birthplace Monroe Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Meyer
15. Birthplace Monroe Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Conrad Lubbert
(b) Address Apple Ave

17. (a) Burial (b) Date thereof Dec. 31 1940
(Burial, cremation or entombment) (Month) (Day) (Year)
(c) Place: burial or cremation Apple Cemetery

18. (a) Signature of funeral director H. H. Stroup
(b) Address Mo. Mo

19. (a) Dec. 30, 1940 (b) Mrs. Louis E. Cook
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. 29 day 1940
year _____ hour 5 o'clock minute P M.

21. I hereby certify that I attended the deceased from noon
killed at work 19 _____ to _____ 19 _____
that I last saw him alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Accidental
gun shot

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) gun shot
(b) Date of occurrence 12/28/40
(c) Where did injury occur? near his home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial plant, in public place?
on a farm near his home
While at work? no (Specify type of place) (e) Means of injury gun shot

23. Signature H. G. Speerberg (M. D. or other) _____
Address Apple Ave Date signed 12/28/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

X21492
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *A H Strop*

Licensed Embalmer No. 2924

P. O. Address *Meto Ma*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43153
Registrar's No. 50

Registration District No. 542

Primary Registration District No. 5731

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Jackson T.P.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Jerome Stevel Lambert
3. (b) If veteran _____ name war _____
3. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 3, 1925
(Month) (Day) (Year)

8. AGE: Years 15 Months 2 Days 25
If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 17, 1941 (b) Mrs. Louis Eada
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH: Month Dec day 28
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature H. G. Lambert (M. D. or other) _____

Address Argyle, Mo. Date signed _____

SUPPLEMENTARY

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Individual 7

S-43153

2001

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2001

2001