

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

Do not use this space.

6676

1. PLACE OF DEATH

County St. Louis
Township St. Louis
City Mo.

Registration District No. 791
Primary Registration District No. 1903

File No. 1498
Registered No. 1498
St. _____ Ward _____

2. FULL NAME

Barney Roebber (BARNEY ROEBER)

(a) Residence, No. COLUMBIA ILL. St. 17 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U.S., if of foreign birth? 25 yrs. 1 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3

MEDICAL CERTIFICATE OF DEATH

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 Barbara Neupenberg
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 5 - 1861
7. AGE YEARS 68 MONTHS 6 DAYS 0 IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Railroad work Mo & R R
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY) Hanover

PARENTS
10. NAME OF FATHER Barheid Roebber
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY) unknown
12. MAIDEN NAME OF MOTHER Edheid Schment
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY) unknown

14. INFORMANT Minnie Roebber
(Address) Columbia Ill

15. FILED: _____ 19 _____
Wm C. Farley REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 11. 1930.
17. I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1930, to Feb. 11, 1930, that I last saw him alive on Feb. 11, 1930; and that death occurred, on the date stated above, at 10:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(1) Rt. Lower Lobe Pneumonia
92c (duration) _____ yrs. _____ mos. 3 ds.
CONTRIBUTORY (SECONDARY) Chronic Myocarditis (2) Chronic nephritis
(duration) 2-3 yrs. mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. undetermined
(2) DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? (1) X-ray Chest (2) Urin Analysis
(Signed) Blanch J. Almond, M. D.
, 19 _____ (Address) 1755 So. Grand 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 East St Louis Ill DATE OF BURIAL 7/17 1930

20. UMBERTAKER Frank Lueder ADDRESS 12th and State East Louis

Exact statement of OCCUPATION is very important.

10 114

**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 St. Louis Registration District No. 791 File No.
 Township Primary Registration District No. 1003 Registered No. 1498
 City St. Louis (No.) St. Ward)

2. FULL NAME

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/11 1930

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

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

Right lower lobe pneumonia
of bacterial origin
as determined
by Dr. B. J. Ayres
Phys. of M.S. 4-20-30 yrs. mos. ds.

8. OCCUPATION OF DECEASED

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

CONTRIBUTORY (SECONDARY)

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

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

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH? DATE OF

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

WAS THERE AN AUTOPSY?

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS?

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

(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, or HOMICIDAL.

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED APR 29 1930 Wm. C. Farley REGISTRAR

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-6676