

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

Do not use this space.

20378

1. PLACE OF DEATH

County Shelby
Township Clare
City Clarence (No. _____)

Registration District No. Dr. Harlan 827
Primary Registration District No. 7500

File No. _____
Registered No. 18
St. _____ Ward _____

2. FULL NAME

Mrs. Lydia Loft
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ernie Loft,
6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 17 1904

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<u>23</u>	<u>2</u>	<u>9</u>	

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Dredford

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

12. MAIDEN NAME OF MOTHER Dollie Tier

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

14. INFORMANT Mrs. Dollie Tedford
(Address) Clarence, Mo.

15. July 9 1927 Ray Harlan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 26 1927

17. I HEREBY CERTIFY That I attended deceased from March 29 1927 to June 26 1927
that I last saw her alive on June 10 1927, and that death occurred, on the date stated above, at 11:20 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Bilateral Pulmonary Tuberculosis
2 1/2 yrs. (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at place of death
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Spatter Examination

(Signed) D. R. Harlan M. D.

(Address) Clarence 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 Maplewood DATE OF BURIAL June 28 1927

20. UNDERTAKER E. E. Hopper ADDRESS Clarence Mo

K. 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.

