

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

Do not use this space.

2527

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. 791
Primary Registration District No. 1003

File No.
Registered No. 68
St. Ward

2. FULL NAME

(a) Residence. No. 2023 7 10⁴ St. 25 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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 Dora Lighthall

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 27 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 7 4

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Tax Payer 186A 1945 1570
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

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

10. NAME OF FATHER David Lighthall

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

12. MAIDEN NAME OF MOTHER U. Y.

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

14. INFORMANT Mrs Dora Lighthall
(Address) 2023 7 10⁴ St

15. FILED 41-3 1028 May 6 Starckoff
1928

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-1-28

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.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cellulitis of scalp following I pack & Injury
menoragin fall from
Building (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Accident
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 188
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY Yes
WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Wm. Dyer
1/5 1928 (Address) Dep. Comm.

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary DATE OF BURIAL 1-4-28

20. UNDERTAKER Arthur J. Donnelly ADDRESS 2039 Wash St

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.

