

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

Do not use this space.

31622

1. PLACE OF DEATH

County Pulaski
Township Union
City Dixon (No. _____)

Registration District No. 711
Primary Registration District No. 3940

File No. 19
Registered No. 16
St. _____ Ward _____

2. FULL NAME

John Henry Light
(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 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 Sista Light

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-9-1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 9 18

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)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Indiana

10. NAME OF FATHER Jessie Light

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

12. MAIDEN NAME OF MOTHER Nancy Talbot

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

14. INFORMANT Sista Light
(Address) Dixon Mo.

15. FILED 9/30, 1929 A. S. Licht REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27- 1929

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to Sept 27, 1929 that I last saw him alive on Sept 26, 1929 and that death occurred, on the date stated above, at 5-0 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Organic Heart-disease

924 (duration) yrs. mos. ds.
4514

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

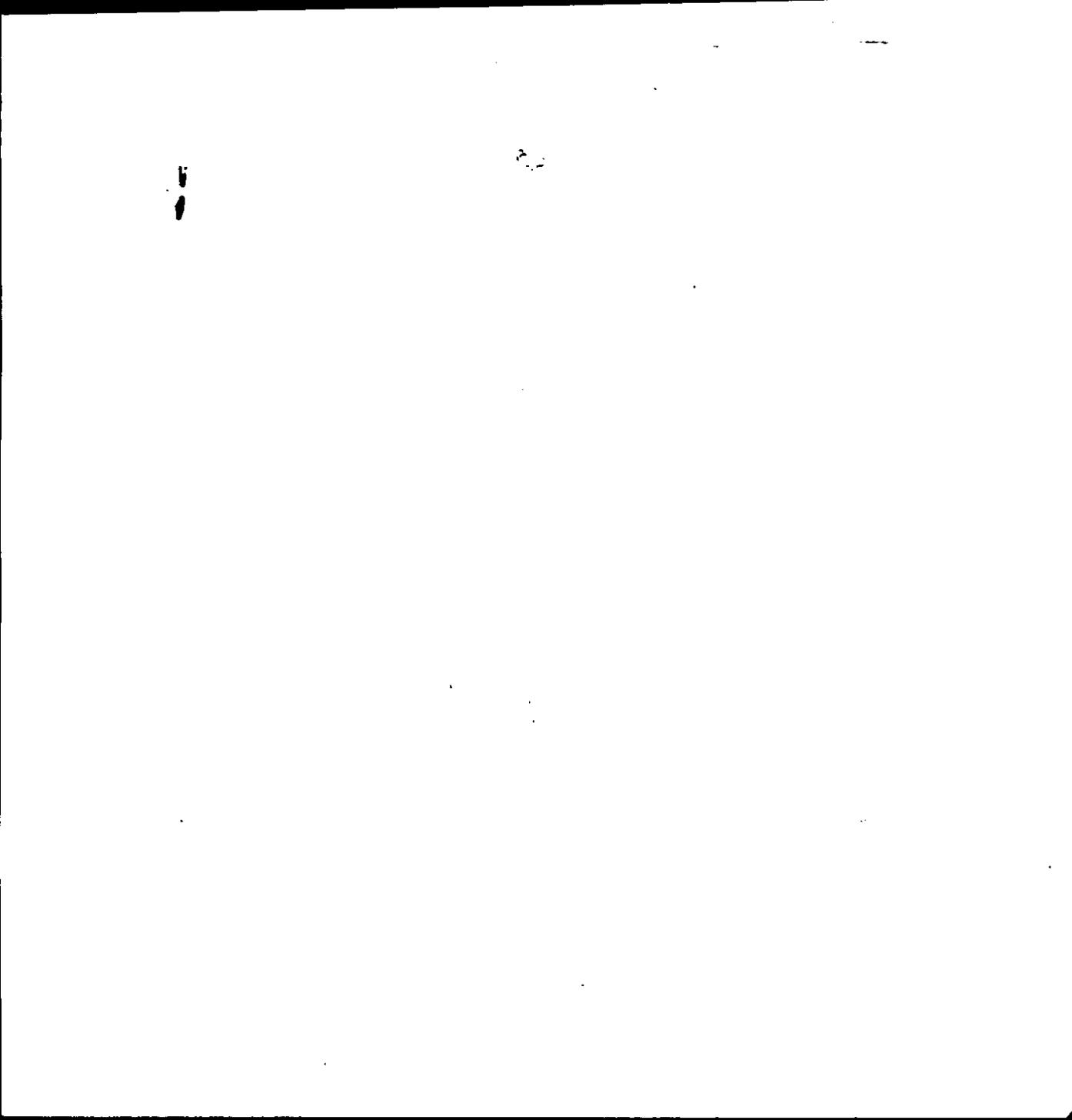
(Signed) E. J. [Signature], M. D.
, 19 (Address) Dixon Mo

*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 Dixon DATE OF BURIAL Sept 27 1929

20. UNDERTAKER Fred W. Glickens ADDRESS Dixon Mo.

2A 1929 102



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Pulaski Registration District No. 911 File No. 19
 Township Union Primary Registration District No. 3940 Registered No. 16
 City..... (No..... St..... Ward)

2. FULL NAME

John Henry Light
 (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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS	MONTHS
		DAYS
	If LESS than 1 day,hrs. ormin.	
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.....		

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

PARENTS	10. NAME OF FATHER
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT.....
 (Address)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27 1929
 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:
Organic Heart Disease
(Valvular)
 (duration)..... yrs..... mos..... ds.
 CONTRIBUTORY (SECONDARY)
900
 (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED.....
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed) John Henry Light, M.D.
 , 19 (Address) Union 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	DATE OF BURIAL
	19

20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRINTED

FILED 9/30 1929 Ad Dick
 REGISTRAR

S-31622