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

Do not use this space.

3194

1. PLACE OF DEATH

County ..... Registration District No. 791 ~~1003~~ File No. 410

Township ..... Primary Registration District No. ..... Registered No. .....

City St. Louis, Mo. (No. 6329 Laura Avenue St. ..... Ward)

2. FULL NAME Austin Milton Lofland

(a) Residence. No. 6329 Laura Avenue St. 7 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24th, 1906

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	24	5	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Private Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Crawfordsville, 2
(STATE OR COUNTRY) Indiana

PARENTS

10. NAME OF FATHER William Lofland

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown 31

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Evelyn Lofland
(Address) 6329 Laura Avenue

15. FILED 11, 19.. Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 8th, 19 31.

17. I HEREBY CERTIFY, That I attended deceased from Oct 26, 1930, to Jan 8, 1931 that I last saw him alive on Jan 7, 1931, and that death occurred, on the date stated above, at 8:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia

154

36

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Chronic Osteomyelitis of Right Femur (duration) 2 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 154

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) O. G. Raines, M. D

1/10, 1931 (Address) 320 Metro Bldg

*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
Valhalla	Jan. 12, 19 31.
20. UNDERTAKER Wacker-Helderly	ADDRESS 2331 S. Brdwy.

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.