

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

Do not use this space.

23120

**1. PLACE OF DEATH**

49 County Jasper  
4 Township Centerville  
2 City Centerville (No. ....) St. .... Ward)

Registration District No. 407  
Primary Registration District No. 4241

File No. ....  
Registered No. ....

**2. FULL NAME**

Miss Emma Louise Loomis

(a) Residence. No. 519 C. Mann St. 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**

Female

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Widowed

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** July 13 1932

**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 ..... 40 m.

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

Widowed

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Died without medical attention  
Probably a poplexy.

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

May 27 1845

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
87	1	17	

OKA (duration) yrs. mos. ds.

**8. OCCUPATION OF DECEASED**

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

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

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Ohio

**18. WHERE WAS DISEASE CONTRACTED** ①  
IF NOT AT PLACE OF DEATH.....

**10. NAME OF FATHER**

Anthony Staves

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

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) W. W. Waggoner, M. D.

. 19 (Address) Co. Health Com

\*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.

PARENTS

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Ind.

**12. MAIDEN NAME OF MOTHER**

Unknown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Unknown

**14. INFORMANT**

(Address) Mrs. Pearl Bryant  
Centerville, Mo.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Mount Hope Cem DATE OF BURIAL 7/15 1932

**15. FILED**

7/15 1932 J. W. Clark  
REGISTRAR

**20. UNDERTAKER** North City Chas Co ADDRESS North City

N. B.—Every item of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 24 1932

