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

Do not use this space.

OCT 1 3 1934

1. PLACE OF DEATH

County: St Francois — Registration District No. 771

Township: — Primary Registration District No. 4462

City: Bismarck (No. ..., ... St. ..... Ward)

File No. 33909

Registered No. .....

2. FULL NAME Loretta Fern Lahman

(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 (write the word): S

5A. If ~~MARRIED, WIDOWED, OR DIVORCED~~ HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 15 - 1934

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
—	2	1	

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: .....

9. BIRTHPLACE (CITY OR TOWN): Bonne Terre

(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Arthur C Lahman

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

12. MAIDEN NAME OF MOTHER: Fern Hamrick

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

14. INFORMANT: Arthur C. Lahman
(Address): Bismarck, Mo

15. FILED Oct 10, 1934. E. M. Bryan MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 16 - 1934

17. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1934, to Sept 16, 1934 that I last saw he alive on Sept 16, 1934, and that death occurred, on the date stated above, at 6.45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Dysentery

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) .....

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

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

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Edward M Papp, M. D

Sept 17, 1934 (Address) Bismarck 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: I.O.O.F. Bismarck, Mo.

DATE OF BURIAL: Sept 17, 1934

20. UNDERTAKER NONE.

WM. ROME (SEXTON of IOOF Cemetery)

ADDRESS: Bismarck Mo

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.