

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

Do not use this space.

**1. PLACE OF DEATH** *JUN 28 1937*  
 County *St. Clair* Registration District No. *763*  
 Township *Butler* Primary Registration District No. *4458*  
 City *Louisy City Mo* (No. *2*) St. \_\_\_\_\_ (Ward) \_\_\_\_\_

**2. FULL NAME** *Isaac Wesley Lotz*  
 (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 *41* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. *21180*  
 Registered No. *7*

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** *Male* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** *widowed*  
**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** *Darah Fernhast Lotz*  
**6. DATE OF BIRTH (MONTH, DAY, AND YEAR)** *Aug. 31, 1847*  
**7. AGE** YEARS *89* MONTHS *8* DAYS *8* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
**8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.** *Retired*  
**9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.** \_\_\_\_\_  
**10. Date deceased last worked at this occupation (month and year)** \_\_\_\_\_ **11. Total time (years) spent in this occupation** \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)** *5/9/1937*  
**22. I HEREBY CERTIFY, That I attended deceased from** *May 4, 1937* to *May 9, 1937*  
 I last saw him live on *May 8, 1937* Death is said to have occurred on the date stated above, at *5:30 p.m.*  
 The principal cause of death and related causes of importance were as follows:

*paralysis* Date of onset

Other contributory causes of importance:

**12. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY)** *Portland Jay County Ind.*  
**13. NAME** *James G. Lotz*  
**14. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY)** *not given Jay Co. Ind.*  
**15. MAIDEN NAME** *Mary White*  
**16. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY)** *near Portland Jay Co. Indiana*  
**17. INFORMANT (ADDRESS)** *W. E. Lotz Louisy City Mo*  
**18. BURIAL, CREMATION, OR REMOVAL** PLACE *Louisy City Ind.* DATE *5/11/1937*  
**19. UNDERTAKER (ADDRESS)** *A. C. Austin Louisy City Mo*  
**20. FILED** *May 10, 1937* *Sophia A. Stratton Registrar.*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
**23. If death was due to external causes (violence), fill in also the following:**  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
**24. Was disease or injury in any way related to occupation of deceased?**  
 If so, specify \_\_\_\_\_  
 (Signed) *C. S. Stratton* M. D.  
 (Address) *Louisy City 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Clair Registration District No. 763 File No. 21180  
 Township \_\_\_\_\_ Primary Registration District No. 4458 Registered No. \_\_\_\_\_  
 City Louisy City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Word \_\_\_\_\_  
 (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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. or min.  
89 8 8

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. UNDERTAKER (ADDRESS)

20. FILED May 10 1937 Sophie L. Stratton (Address) Louisy City no

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/91 1937

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Paralysis Cerebral hemorrhage

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) C. S. Stratton \_\_\_\_\_, M. D.

(Address) Louisy City no

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

081H-5