

REC'D SEP 28 1938

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

29787
Do not use this space.

1. PLACE OF DEATH

(a) County Tolk Registration District No. 708
(b) Township McKinley Primary Registration District No. 59370 Registered No. 21
(c) City (d) Street No.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Arthur Mitchell Lightfoot 2nd St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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 Mary Lightfoot
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 17-79
7. AGE YEARS 59 MONTHS 2 DAYS 20 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 3 1938
22. I HEREBY CERTIFY that I attended deceased from Sept 1936 to July 1938
I last saw him alive on July 1938 1938. Death is said to have occurred on the date stated above, at 9 P.M.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis Date of onset 1936
Uremia June 1938

Other contributory causes of importance:

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

FATHER 13. NAME Hoak Lightfoot

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

MOTHER 15. MAIDEN NAME Rosanna Phelps

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

17. INFORMANT (ADDRESS) Mary Lightfoot Tolk Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Dayne DATE July 4 1938

19. FUNERAL DIRECTOR (ADDRESS) Mitchell & Blue Bolivar Mo

20. FILED July 7 1938 Mac Zimmert Local 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? no
If so, specify

(Signed) Doyle C. Miller, M.D.
Bohrman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

928 ✓

RECEIVED.

District Health Officer No. 71

District File Number 7-38-101

Date Filed 9/13/35

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

L. E. _____

No. _____ or by _____
working under my personal supervision.

RECEIVED

Registered Apprentice No. _____

District Health Officer No. 71

Signed _____

Licensed Embalmer No. _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

29787

Do not use this space.

1. PLACE OF DEATH

(a) County Polk Registration District No. 208
 (b) Township 2nd Mc Kinley Primary Registration District No. 3937a Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Arthur Mitchell Lightfoot
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (write the word)

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.
59 - 20

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)

FATHER
 13. NAME

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

MOTHER
 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 3, 1928

22. I HEREBY CERTIFY, That I attended deceased from 19____ to 19____

I last saw him 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:

Chronic nephritis
Chronic nephritis

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) Doyle C. Mc Graw, M. D.

(Address) Bahavar _____

SUPPLEMENT

S-29787