REC'D SEP 28 1938

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

30131
Do not use this space.

1. PLACE OF DEATH
(a) County: Shannon
(b) Township: Eminence
(c) City:
Registration District No.: 824
Primary Registration District No.: 6076
Registered No.:
(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: Martha Ann Loftin
(a) Residence, No.: 125 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

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: B. F. Loftin

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
77	4	13	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: None
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): Mo 0

FATHER
13. NAME: Ephriam Hyde 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio 1

MOTHER
15. MAIDEN NAME: Rebecca Crouse
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio

17. INFORMANT (ADDRESS): Ira Fry Cactus Fork Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Bay Country DATE: 8-18-38

19. FUNERAL DIRECTOR (ADDRESS): Noel

20. FILED: 8-18 1938 Frank Hyde MD
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug-17- 1938

22. I HEREBY CERTIFY, That I attended deceased from Mar-10- 1937, to Aug-17- 1938
I last saw her alive on May 26 1938. Death is said to have occurred on the date stated above, at 6 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cancer of Breast	
50 yr	

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) Frank Hyde, M. D.
(Address) Eminence Mo

(Licensed Embalmer's Statement on Reverse Side)

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....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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(b) Township Eminence — Primary Registration District No. 6076 — 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 Martha Ann Lofton
(a) Residence, No. 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

3. SEX F
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) Apr 4 - 1861

7. AGE — YEARS 77 — MONTHS 4 — DAYS 13 — If LESS than 1 day, hrs. or min.

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 8-19- 1938 Frank Hyde MD Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 17 1938

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

Cancer of Breast

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) Frank Hyde , M. D.
(Address) Eminence Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

(a) County ..... Registration District No. .....

(b) Township ..... Primary Registration District No. ..... 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 .....

(a) Residence, No. ..... 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

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

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

S-30131

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

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

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) ....., 19....

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., I last saw it 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:

	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) ....., M. D.

(Address) .....