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

REC'D APR 12 1939

791
1008

9147
Do not use this space.

1. PLACE OF DEATH

(a) County 2 Registration District No.

(b) Township Primary Registration District No. Registered No. 2912

(c) City St. Louis 1 (d) Street No. 3954 Shenandoah 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 12 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 231 Thomas P. Lightfoot

(a) Residence, No. 3954 Shenandoah Street St. 17
(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: 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: Grace Lightfoot

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): December 18, 1863

7. AGE: YEARS 75 | MONTHS 3 | DAYS 8 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Policeman
9. Industry or business in which work was done, as saw mill, bank, etc.: Washington, D. C.
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): Luaden County, Virginia

FATHER
13. NAME: John T. Lightfoot 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Luaden County, Virginia 1

MOTHER
15. MAIDEN NAME: Elizabeth Emerson 1
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Luaden County, Virginia

17. INFORMANT (ADDRESS): Grace Lightfoot, 3954 Shenandoah Street

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cemetery DATE March 29, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Wm. J. Robert, 1905 So. Grand Blvd.

20. FILED MAR 28 1939 J. F. Budeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): March 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 13, 1939, to March 26, 1939
I last saw him alive on March 25, 19.... Death is said to have occurred on the date stated above, at 12.40 A. M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Tabes dorsalis	several years ago
80	

Other contributory causes of importance:

Paraplegia	March 11 1939
Senile dementia	4 years

Name of operation — Date of —
What test confirmed diagnosis? clinical Was there an autopsy? no

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) W. P. Eidmann, M. D.
(Address) 3146 Morganford

(Licensed Embalmer's Statement on Reverse Side)

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.

Corrected by affidavit Mar 13. L. Wood

See affidavit # 242 in misc file 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, Wm J Robert, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Wm J Robert

Licensed Embalmer No. 502

P. O. Address St Louis Mo

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

If this body is not embalmed, above space should be left blank.

SUPPLEMENTARY

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

Do not use this space.

9147

File No. .....

Registered No. 2912

1. PLACE OF DEATH

County ..... Registration District No. .....

Township ..... Primary Registration District No. .....

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

2. FULL NAME THOMAS P. LIGHTFOOT

(a) Residence, No. 3954 SHENANDOAH St., 17 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	W	

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.

OCCUPATION

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)

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. UNDERTAKER .....
(ADDRESS)

20. FILED 3/11/40 19.... J. F. Budrich
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAR. 26, 1939

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:

	Date of onset
Sclerosis of Spinal Cord	
Not due to Syphilis	
See affidavit File # 242	
Other contributory causes of importance: JWC 3-13-40	

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) W. P. Kidneman, M. D.

(Address) .....

N. B.—Every item of information must be given. If not known, state "Unknown." Do not omit any item. Be sure to state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in terms of disease or injury. Statement of OCCUPATION is very important.