

APR 17 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 399

9676
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson Registration District No. 1002
(b) Township New Primary Registration District No. 1282
(c) City St. Louis (d) Street No. 17 E. Van Buren St. St.
(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 157 Jesse B. Luffman
(a) Residence, No. 3419 Brooklyn St. (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 Walter C. Luffman
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 20 1882
7. AGE YEARS 57 MONTHS 2 DAYS 2 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. clerk
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

FATHER 13. NAME Acharial Luffman

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

MOTHER 15. MAIDEN NAME Sarah Beam

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

17. INFORMANT (ADDRESS) Recard Clerk
St. Louis

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty Mo DATE 3/25/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. J. Mayhew
St. Louis

20. FILED 3-24-39 M. M. Crowe, reg.
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-23-39
22. I HEREBY CERTIFY, That I attended deceased from Sept 12-39 to 3-23-39
I last saw him alive on 3-23-39 Death is said to have occurred on the date stated above, at 7:35 a.m.
The principal cause of death and related causes of importance were as follows:

Papillary adenocarcinoma of caecum with metastases to liver & b and lymph nodes
Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? yes

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? 1
If so, specify.....
(Signed) B. F. De Moya, M. D.
(Address) Sept H. C. St.

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.

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,

....., or by

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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