REC'D APR 11 1939

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

11939
Do not use this space.

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.

1. PLACE OF DEATH
(a) County Platte
(b) Township
(c) City Weston
(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.

Registration District No. 698
Primary Registration District No. 4420
Registered No.

2. PRINT FULL NAME 230 Charles Light
(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: XXX
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Oct 24-1858
7. AGE: YEARS 80 | MONTHS 4 | DAYS 10 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Common Labor
9. Industry or business in which work was done, as saw mill, bank, etc. Retired
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) West Virginia

FATHER
13. NAME Jacob Light
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va. Mary Light

MOTHER
15. MAIDEN NAME Mary Light Va.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

17. INFORMANT (ADDRESS) Mrs Hollenbeck Weston Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Laurel Hill DATE Mar. 7 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J H Bell Weston Mo
20. FILED 3/7 1939 J H Bell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March - 4 - 1939
22. I HEREBY CERTIFY, That I attended deceased from Feb - 24 - 1939, to March - 4 - 1939.
I last saw him alive on March - 4 - 1939 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:
Urosepsis
Date of onset
Other contributory causes of importance: Prostatitis Aptitis, pyelonephritis.
Name of operation None 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) Lewis C. Calvert, M. D.
(Address) Weston, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number 39-198
Date Filed APR 5 1939

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, J. N. Brill, or by .....

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

Signed J. N. Brill

Licensed Embalmer No. 1832

P. O. Address Weston Mo

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

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