S. No. 2
—11-10-39
5-17-39
I X21492

35
2
0

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1940

Registration District No. 272

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10844

Primary Registration District No. 4166

Registrar's No.

1. PLACE OF DEATH:
(a) County: Dunklin
(b) City or town: Campbell
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: —
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: (Specify whether years, months or days)
In this community: Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Dunklin
(c) City or town: Campbell
(If outside city or town limits write "RURAL")
(d) Street No.: —
(If rural, give location)
(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME: Ida Lear Lightfoot
3. (b) If veteran, name war: —
(c) Social Security No.: —
4. Sex: Fem
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: May (Month) 9 (Day) 1880 (Year)

8. AGE: Years	Months	Days	If less than one day
59	10	14	hr. min.

9. Birthplace: Mo (City, town, or county) (State or foreign country)
10. Usual occupation: Home wife
11. Industry or business: " "
MOTHER FATHER
12. Name: Newton Wrathers
13. Birthplace: Tenn. (City, town, or county) (State or foreign country)
14. Maiden name: Sarah J. Thorgmartin
15. Birthplace: Tenn (City, town, or county) (State or foreign country)
16. (a) Informant: Wm Lightfoot
(b) Address: Campbell
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mch 24 40 (Month) (Day) (Year)
(c) Place: burial or cremation: Woodlawn Cem
18. (a) Signature of funeral director: Sanders Funeral Home
(b) Address: Campbell Mo
19. (a) 3/23-40 (Date received local registrar) (b) Tw Sanders (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch day 23 year 1940 hour 7 minute P M.
21. I hereby certify that I attended the deceased from Mar 20 Mar, 19__, to Mar 23, 19 40 that I last saw him alive on Mar 23, 19 40 and that death occurred on the date and hour stated above.

Immediate cause of death: Mitral Regurgitation — Duration
Due to: Influenza 9 weeks before death
Due to:
Other conditions: — (Include pregnancy within 3 months of death)
Major findings: Of operations:
Of autopsy: No

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: John L Brown (M. D. or other)
Address: Campbell Mo Date signed 3/24/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2
District File Number 440-88
Date Filed 4/5/40

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 wi the above constitutes grounds for revocation of license.)

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