

Registration District No. **791**

Primary Registration District No. **1003**

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Phillips Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 mo 13 days**
In this community **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **John Lightfoot**

3. (b) If veteran **SS-488-05-0338** name war _____
3. (c) Social Security No. **UNK**

4. Sex **Male** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Rosie Lightfoot**
6. (c) Age of husband or wife if alive **50 yrs** years

7. Birth date of deceased **March 10 1892**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 8 12 hr. min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER
12. Name **Frank Lightfoot**
13. Birthplace **Mississippi**
(City, town, or county) (State or foreign country)
14. Maiden name **Emma Lightfoot**
15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Rosie Lightfoot**
(b) Address **2955a Dayton St**

17. (a) **Burial** (b) Date thereof **Nov. 27 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **Russell Undt. Co.**
(b) Address **2732 Pine Street**

19. (a) **NOV 27 1940** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **4326 a Page** (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **22**
year **1940** hour **3:20** minute **A** M.

21. I hereby certify that I attended the deceased from **October 9**, 19**40**, to **November 22**, 19**40**;
that I last saw him alive on **November 22**, 19**40**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Heart Disease** Duration **25 yrs**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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? _____

While at work? (Specify type of place) (e) Means of injury _____

28. Signature **J. W. Johnson** (M. D. or other) _____
Address **2601 N Whittier** Date signed _____

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 X1931

USE WRITING BLACK INK—MAKE A PERMANENT RECORD

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.....

Joel Russell

Licensed Embalmer No. *4112*

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.