

FILED FEB 14 1941

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

2500

Do not use this space.

1. PLACE OF DEATH

(a) County St. Clair Registration District No. 931
(b) Township Central Primary Registration District No. 4 Registered No. 36
(c) City St. Clair (d) Street No. 1 (If death occurred in Hospital or Institution, write its name instead of street and number) 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. da.

2. PRINT FULL NAME LAFAYETTE LOUGH

(a) Residence, No. 1 St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN. 18, 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. LABORER
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) MISSOURI13. NAME SYLVESTER LOUGH14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI15. MAIDEN NAME MARGARET JUMP16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI17. INFORMANT EDWIN LOUGH
(ADDRESS) ST. CLAIR MO.18. BURIAL, CREMATION, OR REMOVAL PLACE GREEN MOUND DATE JAN. 22, 194119. FUNERAL DIRECTOR (NAME) CASEY & LENOX
(ADDRESS) ST. CLAIR, MO.20. FILED Feb 9, 1941 T. H. Duckworth
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 19, 194122. I HEREBY CERTIFY That I attended deceased from Jan 18, 1941, to Jan 19, 1941

I last saw him alive on Jan 18, 1941. Death is said to have occurred on the date stated above, at 5A. m.
The principal cause of death and related causes of importance were as follows:

SepticemiaDate of onset ?Other contributory causes of importance: 10?Name of operation clin 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 ?
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 with occupation
(Signed) J. C. Jones, M. D.
(Address) St. Clair, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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No. 35

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FORMER 4

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 *K.M. Lerut*

Licensed Embalmer No. *3601*

P. O. Address *St. Clair, Mo.*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2500

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 294

Primary Registration District No. 4178

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town St. Clair
(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 _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Lafayette Lough

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 67 Months - Days 18 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 3/27/44 (b) W. H. Duckworth
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin

(c) City or town St. Clair - Rural
(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.

20. DATE OF DEATH: Month Jan day 19
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19 _____, to _____, 19 _____; that I last saw him _____ alive on _____, 19 _____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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) _____ (a) Means of injury _____

23. Signature W. H. Duckworth (M. D. or other) _____
Address St. Clair _____ Date signed _____

SUPPLEMENTARY

