

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

26332

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED AUG 12 1946

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 888

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
On sidewalk in front of 622 No. 9th  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \*  
(Specify whether in this community Lifetime years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 811 No. 9th. St.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \*

3. (a) PRINT FULL NAME Franklin Andrew Lofflin

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5  
year 1946 hour 6 minute 30 A.M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Gertrude

6. (c) Age of husband or wife if alive \* years

7. Birth date of deceased November 14 1904  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 5th, 1946, to         , 19        ;  
that I last saw h          alive on         , 19        ;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

41	8	21	hr. min.
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Immediate cause of death Cerebral Apoplexy Duration         

9. Birthplace St. Joseph Missouri  
(City, town, or county) (State or foreign country)

Due to         

Due to         

10. Usual occupation Barber

Other conditions           
(Include pregnancy within 3 months of death)

11. Industry or business Ray James Barber Shop

Major findings:  
Of operations           
Of autopsy         

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

12. Name James W. Lofflin

13. Birthplace Unknown Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Mary E. Schaille

15. Birthplace Unknown Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. James W. Lofflin

(b) Address Industrial City, Mo.

17. (a) Burial (b) Date thereof Aug. 7, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Herman W. Anderson

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) Aug. 7, 1946 (b) H. J. Nestlebusch  
(Date received local registrar) (Registrar's signature)

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         

23. Signature B. W. Tadloe (M. D. or other) Coroner

Address King Hill Bldg Date signed 8/6 46

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

251 198

34

(Licensed Embalmer's Statement on Reverse Side)

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**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.....

*Thomas Thomas*

Licensed Embalmer No.....

*2640*

P. O. Address.....

*St. Joseph 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, fact should be so stated above.**