No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 18 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39271

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 261

1. PLACE OF DEATH:
(a) County RANDOLPH
(b) City or town MOBERLY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution WABASH EMPLOYES' HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAYS (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County RANDOLPH 88
(c) City or town MOBERLY 6
(If outside city or town limits, write "RURAL")
(d) Street No. 825 WEST REED STREET 3
(If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ALFRED T LIGHTFOOT
3. (b) If veteran, name war ✓
3. (c) Social Security No. 702-05-5772

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Grace
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 9th (Day) 1865 (Year)

8. AGE: Years 82 Months 4 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) Pa (State or foreign country)
10. Usual occupation Rtd. Machinist
11. Industry or business Wabash R R
FATHER
12. Name George Lightfoot
13. Birthplace (City, town, or county) No data (State or foreign country) 9
MOTHER
14. Maiden name "
15. Birthplace (City, town, or county) " (State or foreign country) 9
16. (a) Informant Mrs Grace Lightfoot
(b) Address Moberly, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-47 (Month) (Day) (Year)
(c) Place: burial or cremation Moberly Mo
18. (a) Signature of funeral director Mahan and Son
(b) Address Moberly Mo
19. (a) 11-15-47 (Date received local registrar) (b) Leah W Lowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 12 year 1947 hour 8 minute 00 P M.

21. I hereby certify that I attended the deceased from NOV 10, 1947 to NOV 12, 1947 that I last saw him alive on NOV 12, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death MESENTERIC OCCLUSION	4 DAYS
Due to MESENTERIC EMBOLISM	
Due to ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	15 YEARS
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations GANGRENOUS INTESTINE WITH THROMBOSED MESENTERIC VESSELS	
Of autopsy	

PHYSICIAN
Underline the cause of 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 [signature] (M. D. or other) MD
Address Moberly, Mo Date signed Nov 14/47

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

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

DEC 30 1947

FEB 8 1951

RECEIVED
District Health Officer No. 10
District File Number 11-47-1576
Date Filed NOV 17 1947

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 Frank B. DeNutt

Licensed Embalmer No. 3021

P. O. Address Moberly 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.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 261

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

3. (a) PRINT FULL NAME Alfred T. Lightfoot

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 M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Years

7. Birth date of deceased July 9 1866
(Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) Nov 15-47 (Date received local registrar) (b) Leah Vaccaro Lowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 2 year 1947 hour minute M.

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

Immediate cause of death — Duration

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

39271