

FILED JUL 29 1948

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23875

State File No. _____

Registration District No. 282

Primary Registration District No. 5971

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Marion, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
in car on Highway D on way in to Bolivar.
(If not in hospital or institution, write street number or location)
to see doctor.
(d) Length of stay: In hospital or institution 3
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk
(c) City or town "Rural" N. McKinley Twp.
(If outside city or town limits, write "RURAL")
(d) Street No. Star Rt. Flemington
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Arlinda Lou Lightfoot

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

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced D
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 6 1948
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 12 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Robert Lee Lightfoot
13. Birthplace Polk County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Geneva Pearl Lightfoot
15. Birthplace Polk County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Robert L. Lightfoot
(b) Address Star Rt. Flemington, Mo.
17. (a) burial (b) Date thereof July 21, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cem. Adonis, Mo.

18. (a) Signature of funeral director Turpin Funeral Home
Bolivar, Mo.
(b) Address _____

19. (a) July 21, 1948 (b) Ralph Gordon
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1948 hour 10 minute 05 A. M.

21. I hereby certify that I attended the deceased from June 6
1948, to July 16, 1948
that I last saw her alive on July 16, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure Duration 10 min
Due to Congenital Heart disease 1 mo. 12 days

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

Major findings: 1576 PHYSICIAN _____
Of operations _____
Of autopsy _____
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 D
23. Signature W. W. Tillman Jr. (M. D. or other) M.D.
Address Bolivar, Mo. Date signed 7-19-48

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

RECEIVED

District Health Officer No. 71

District File Number 540

Date Filed 7-27-48

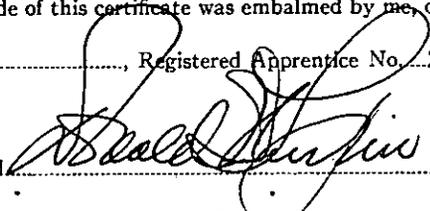
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Charles F. Fox
working under my personal supervision.

....., Registered Apprentice No. 22

Signed.....



Licensed Embalmer No. 3053

P. O. Address Bolivar, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 282

Primary Registration District No. 591

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Polk
(b) City or town North Marion
(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 Arinda L Lightfoot

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

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

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

7. Birth date of deceased June 6 (Month) (Day) (Year)

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

9. Birthplace _____ (City, town, or county) (State or foreign country) No

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1948 year _____ month _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19 _____

that I had seen him 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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY 8

S-23875