

Health, Welfare, Public Service, 000-56, Director, coroner, etc. must use only standard nomenclature from the International Classification of Diseases in Part I. Must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 14 1957

4228  
STATE FILE NUMBER  
133

Registration District No. 109 Primary Registration District No. #180 Registrar's No.

|   |                                  |   |  |  |   |   |  |
|---|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Dunklin</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Dunklin</b> |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Campbell</b>  |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  | c. CITY OR TOWN <b>Campbell</b>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF, (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION   |                                  |   |  | Length of stay in lb   |   | d. STREET ADDRESS <b>908 Louis St.</b> (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROBERT</b> Middle <b>WILSON</b> Last <b>LOAFMAN</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>3</b> Year <b>1957</b>   |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 4, 1880</b>   |   | 9. AGE (In years last birthday)<br><b>76</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farming &amp; Factory Work</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><b>Hickman county, Kentucky</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>James M. Loafman</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Laicia Thompson</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>431-18-2968</b>   |  | 17. INFORMANT<br><b>908 Louis St. Carrie Loafman, Campbell, Mo.</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b>   |                                  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 min.</b>   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |                                  |   |  |  |   | DUE TO (b) <b>Acute Bronchial Asthma</b><br>DUE TO (c)  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |   |   |  |
| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____<br>a. m. _____ p. m. _____   |                                  |   |  |  |   |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 20f. CITY, TOWN, OR LOCATION   |   | CITY _____ COUNTY _____ STATE _____   |  |
| 21. I attended the deceased from <b>3/3/57</b> to _____ and last saw her/him alive on <b>3/3/57</b><br>Death occurred at <b>11:40 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |  |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Wallace Belsey M.D.</b>  |                                  |   |  | 22b. ADDRESS<br><b>Campbell Mo.</b>  |   | 22c. DATE SIGNED<br><b>3/5/57</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE<br><b>Mar. 6, 1957</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hopwood Cemetery</b>                                |  | 23d. LOCATION (City, town, or county) (State)<br><b>Campbell, Missouri R. 2</b> |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Landess Funeral Home, Campbell, Mo.</b>  |                                  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>3-6-1957</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Beulah Campbell</b>  |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED DUNKLIN COUNTY HEALTH

DEPARTMENT 3-12-5

COUNTY FILE NUMBER 357

MAR 20 1957

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 ....., Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *Christina M. Landrum*

Licensed Embalmer No. 42

P. O. Address *Camp*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.