

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.

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

36054
Do not use this space.

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 315
 (b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 738
 (c) City SPRINGFIELD (d) Street No. 809 S Missouri St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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. ds.

2. PRINT FULL NAME Asa Loren Lovelace
 (a) Residence, No. 809 S Missouri 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sela Belle Lovelace

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 17, 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>72</u>	<u>5</u>	<u>16</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Ret. R.R. Employee
 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) Greene County, Mo.

FATHER
 13. NAME Walc
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER
 15. MAIDEN NAME Walc
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Sela Belle Lovelace, Springfield, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Local Burial DATE Oct 5, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alma Johnson, Springfield, Mo.
 20. FILED Oct 6, 1939 Chas. H. Hooper Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 3, 1939

22. I HEREBY CERTIFY, That I attended deceased from 8-1, 1937, to Oct 3, 1939.
 I last saw him alive on Oct 3, 1939. Death is said to have occurred on the date stated above, at 5:30 P.M.
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
 Other contributory causes of importance:
Hypertensive C-V disease
Cardio-vascular

Name of operation _____ Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? no

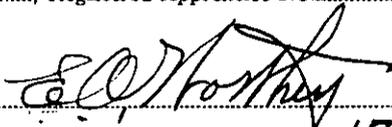
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) R. M. White, M. D.
 (Address) Springfield

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..... 
Licensed Embalmer No..... 1767
P. O. Address.....

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.

X