

RECEIVED OCT 23 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32843

State File No. _____

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. 101

1. PLACE OF DEATH:

(a) County Shepherd
(b) City or town Rural - Rural
(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 2
(Specify whether
In this community 3 1/2
years, months or days)

3. (a) PRINT FULL NAME Daniel Weldon Love

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

4. Sex WM 5. Color or race Wh 6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased Nov. 1, 1888
(Month) (Day) (Year)

8. AGE: Years 56 Months 9 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name R. A. Love

13. Birthplace Shepherd Mo (City, town, or county) (State or foreign country)

14. Maiden name Ellen Brown

15. Birthplace James Prairie Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. J. Sellers

(b) Address Rural - Rural

17. (a) Burial (b) Date thereof Aug 14, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miller farm

18. (a) Signature of funeral director Daniel W. Love
(b) Address Rural - Rural

19. (a) Aug 17, 1940 (b) Jos. F. Ayers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shepherd
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Rural Hotel
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15
year 1940 hour _____ minute _____ M.

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

Immediate cause of death Aortic Aneurysm

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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? W/O

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

23. Signature Oral E. Licklider (M.D. or other) corner
Address St James Mo Date signed 8-16-40

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

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

RECEIVED

District Health Officer No. 5,

District File Number 1040988

Date Filed _____

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 S. L. Miles

Licensed Embalmer No. 3397

P. O. Address Rolla 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, above space should be left blank.