

FILED NOV 12 1940

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4079**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: The Children's Mercy Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether)
 In this community Same
years, months or days

3. (a) PRINT FULL NAME Carl Loveall
3. (b) If veteran, name war -
3. (c) Social Security No. -

4. Sex male **5. Color or race** white **6. (a) Single, widowed, married,** divorced -
6. (b) Name of husband or wife - **6. (c) Age of husband or wife if** - years
7. Birth date of deceased June 15 1937
(Month) (Day) (Year)

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

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

10. Usual occupation Infant

11. Industry or business -
12. Name William Loveall
13. Birthplace St. Louis, Mo
(City, town, or county) (State or foreign country)
14. Maiden name Ethel Elaine
15. Birthplace Chilhowee Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Wells Loveall
(b) Address Chilhowee, Mo

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10-20-40
(Month) (Day) (Year)
(c) Place: burial or cremation Chilhowee Cem

18. (a) Signature of funeral director William Furman
(b) Address Clinton

19. (a) Oct 18 1940 (Date received by Registrar) **(b) M. M. Crowe** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Chilhowee
(If outside city or town limits, write "RURAL")
 (d) Street No. 0
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? - years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 18
 year 1940 hour 6 minute 15 P. M.
21. I hereby certify that I attended the deceased from 10-16
1940, to 10-18, 1940;

that I last saw him alive on 10-18-40, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Gastroenteritis
 Due to Dehydration
 Due to Exposure 12-13
 Other conditions (Include pregnancy within 3 months of death)

Major findings: -
 Of operations -
 Of autopsy Same

Duration

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 W. S. Doderberg (M. D. or other)
 Address 1316 Prof 15th Date signed 10-18-40

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.....

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, fact should be so stated above.