

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

39197
 Do not use this space.

1. PLACE OF DEATH

(a) County Maries Registration District No. 546
 (b) Township Johnson Primary Registration District No. 5735
 (c) City 2 (d) Street No. 1325
 (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.

Registered No. 17

2. PRINT FULL NAME Joseph W. Love

(a) Residence, No. Maries Co Mo Rural 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) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rhoda Love

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 6, 1854

7. AGE YEARS 86 MONTHS 0 DAYS 17 IF LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
 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) High Gate Mo.

FATHER 13. NAME Harvey Love

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER 15. MAIDEN NAME Sands

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT W. F. Love (ADDRESS) Chadwick, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE High Gate, Mo DATE Oct. 24, 1940

19. FUNERAL DIRECTOR S. G. Licklider (ADDRESS) Belle, Mo.

20. FILED 11-19- 1940 Sam A Warner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 22, 1940

22. I HEREBY CERTIFY, That I attended deceased from May 15 1940 to Oct. 23rd 1940

I last saw him alive on July 10 1940 Death is said

to have occurred on the date stated above, at 1 a. m.

The principal cause of death and related causes of importance were as follows:

Bronchial Pneumonia

Date of onset

Other contributory causes of importance: Senility 107W

Name of operation None Date of None
 What test confirmed diagnosis Symptoms 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? no
 If so, specify _____

(Signed) S. G. Licklider M. D.
 (Address) Belle, Mo

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.

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)