

FILED JAN 21 1941

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

43356

Do not use this space.

1. PLACE OF DEATH

(a) County Oregon Registration District No. 631
(b) Township Big Apple Primary Registration District No. 5-833
(c) City 320 (d) Street No. _____ St.
(e) Length of residence in city or town where death occurred 15 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Sept 9 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>Esther Howell</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 16 1899</u>		
7. AGE YEARS <u>49 =</u>	MONTHS	DAYS
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>		11. Total time (years) spent in this occupation
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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Oregon Co - 1/2</u>		
13. NAME <u>Jim Lovelace</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
15. MAIDEN NAME <u>Unknown</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
17. INFORMANT (ADDRESS) <u>Esther Lovelace</u> <u>Keshanony, Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Walker Cem.</u> DATE <u>10/19 40</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Ray Carr</u> <u>Wagon, Mo.</u>		
20. FILED <u>Nov 30 1940</u> <u>Gertrude Hossapple</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-18 40

22. I HEREBY CERTIFY, That I attended deceased from Oct 10 1940 to Oct 16 1940
I last saw him alive on Oct 10 1940. Death is said to have occurred on the date stated above, at 7:30 m.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage

Other contributory causes of importance: 22 W

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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) H. B. Hull M. D.
(Address) Manmoth Army Club

Hull.

RECEIVED

Health Officer No. 5

File Number

12401171

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.....

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43356

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 631

Primary Registration District No. 2833

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Beasdale, T.P.
(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
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Wade H. Lovelace

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Sept 16 1891
(Month) (Day) (Year)

8. AGE: Years 49 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant Esther Lovelace

(b) Address Koshkonong, Mo

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Feb 25 1941 (Date received local registrar) Yertie Hoangple (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH: Month 10 day 18
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 and that death occurred on the date and hour stated above.

Immediate cause of death

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?

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

23. Signature H. B. Hull (M. D. or other)
Address Mammouth, Mo Date

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

SUPPLEMENTARY

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

S-43356