DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

6306

State File No.

X29484

FILED MAR 19 1942

Registration District No. 1842 Primary Registration District No. 4110 Registrar's No. 76

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

1. PLACE OF DEATH:
(a) County Christian
(b) City or town Ozark Mo. Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County almshouse
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Christian
(c) City or town Ozark Mo
(If outside city or town limits, write "RURAL")
(d) Street No. [illegible]
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Frank Loveland

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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased 1872
(Month) (Day) (Year)

8. AGE: Years 70. Months Days If less than one day hr. min.

9. Birthplace Don't Know
(City, town, or county) (State or foreign country)

10. Usual occupation almshouse Patient

11. Industry or business

FATHER
12. Name Don't Know
13. Birthplace Don't Know
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Don't Know
15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Home Bureau
(b) Address Ozark Mo

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb 7-42 (Month) (Day) (Year)
(c) Place: burial or cremation Ozark, County Farm Cemetery

18. (a) Signature of funeral director T. B. Cheffin
(b) Address Ozark Mo

19. (a) Feb. 26, 1942 (Date received local registrar) (b) Lorette Leonard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6th
year 1942 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 1-1942, 1942 to Feb. 6, 1942
that I last saw him alive on Feb. 6th, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis of bath — Duration
Sequa of long confinement

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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

23. Signature J. H. Wade (M. D. ~~or other~~)
Address Ozark Mo Date signed 2-26-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 342-401
Date Filed MAR 17 1942

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~~ not Embalmed as it was a County Case, from the County church, Registered Apprentice No. _____ working under my personal supervision.

Signed T. B. Chaffee

Licensed Embalmer No. 2192

P. O. Address Ozark Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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STANDARD CERTIFICATE OF DEATH

State File No. 6306

Registration District No. 184 Primary Registration District No. 4110 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Christian
(b) City or town: Ozark
(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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Frank Loveland
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: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) 1 (Day) 1874 (Year)

8. AGE: Years 70 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
MOTHER FATHER
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
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 4 year 1942 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.

	Duration
Immediate cause of death: Paralysis of both legs of long duration	
Due to: Bulbular Paralysis	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 82:1	
Of autopsy	

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY