

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

State File No. **282217**

Registration District No. **193** Primary Registration District No. **5709** Registrar's No. _____

1. PLACE OF DEATH:

(a) County **McDONALD**
 (b) City or town **RURAL - GOODMAN**
 (If outside city or town limits, write "RURAL" and name of township)
1 mi. North of Goodman
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **NEWTON 73**
 (c) City or town **RURAL - GOODMAN**
 (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 **LURIA LOVE**

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

4. Sex **FEMALE** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **WIDOWED**
 6. (b) Name of husband or wife **JAMES LOVE** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **MAY 9 1877**
 (Month) (Day) (Year)

8. AGE: Years **67** Months **2** Days **15** If less than one day _____ hr. _____ min.

9. Birthplace **McDONALD Co. MISSOURI**
 (City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **OWN HOME**

12. Name **NELSON RAWLEY**

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

14. Maiden name **SARAH FRANCES ANDERSON**

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

16. (a) Informant **Mrs. Olive Smith**

(b) Address **Neosho Mo. R#2**

17. (a) **Burial** (b) Date thereof **7-26-1944**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **UNION CEMETERY**

18. (a) Signature of funeral director **Betty Thompson**

(b) Address **Neosho Mo**

19. (a) **7/26/44** (b) **Mrs. C.W. Williams**
 (If received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **24**
 year **1944** hour **5:50** minute **a** . M.

21. I hereby certify that I attended the deceased from **July 13 1944** to **July 23 1944**
 that I last saw her alive on **July 23 1944**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion**

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: Of operations **9/4**

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? _____

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

23. Signature **C.D. James** (M. D. or other) **DO**
 Address **Goodman Mo** Date signed **7/27/44**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6;

District File Number 844-950

Date Filed AUG 22 1944

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.....

Barey Thompson

Licensed Embalmer No.....

3259

P. O. Address.....

Neosho 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, fact should be so stated above.