

S. No. 2
M-8-43
7-5-17-39
I X37823

10002

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 9 1945
Registration District No. 164

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 28

Primary Registration District No. 4252

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

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Centerview
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Centerview
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 20 Yrs.
years, months or days

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

3. (a) PRINT FULL NAME Frank O Lovelace
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bessie Lovelace 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Feb 27 1862
(Month) (Day) (Year)

8. AGE: Years 83 Months 0 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Contractor
11. Industry or business Construction

12. Name Chas Lovelace
13. Birthplace Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Louisa Hewitt
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Lennie L Smith
(b) Address Kansas City Kansas

17. (a) Burial (b) Date thereof 3-23-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Maple Hill, K.C.K

18. (a) Signature of funeral director Sweeney Phillips
(b) Address Warrensburg Mo

19. (a) Mar 23 1945 (b) Leola M. Williams
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 21
year 1945 hour 9 minute 30 P.M.
21. I hereby certify that I attended the deceased from Jan. 3
1945 to March 21, 1945.
that I last saw him in alive on March 21, 1945.
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arteriosclerosis
Due to generalized arteriosclerosis
Due to schulky

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations C 97
Of autopsy C

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 0
23. Signature W. Williams (M. D. or other)
Address Warrensburg Mo Date signed 3-23-45

1001

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.....

J. Earl Priest

Licensed Embalmer No. 3878

P. O. Address Warrensburg 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.