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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26501**
3332
Registrar's No.

FILED AUG 29 1945

Registration District No. Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Corwallen's Home
3215 Campbell Street 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months
(Specify whether)

In this community about 25 years
years, months or days

3. (a) PRINT FULL NAME William J. Love

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Margaret J. Love

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

7. Birth date of deceased Dec 3 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>8</u>	<u>4</u>	hr. min.

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

10. Usual occupation Carpenter

11. Industry or business Retired

MOTHER FATHER

12. Name William Love

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

14. Maiden name Unknown

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

16. (a) Informant Mr. Urgel Hoyer

(b) Address Kansas City, Missouri

17. (a) Burial (b) Date thereof Aug 9, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Missouri

18. (a) Signature of funeral director H. H. Newcomer, D.D.

(b) Address 1401 Brush Creek Blvd.

19. (a) 8-8-45 (b) St. Pauline Helms
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 44

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3215 Campbell Street
(If rural, give location)

(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7
year 1945 hour 8 minute — M.

21. I hereby certify that I attended the deceased from June 22
1945, to Aug 7, 1945;
that I last saw him alive on —, 19—;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to Stomach Ulcers

Due to —

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

Major findings:
Of operations —

Of autopsy —

Duration —

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

22. If death was due to — causes, fill in the following:

(a) Accident, suicide, or — (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 Mary J. Tower (M. D. or other) M.D.
Address 7116 Walnut Date signed Aug 8, 1945

Dr. Mary J. Lewis
4116 Walnut
We 6634

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 Emile M. Catbourn
Licensed Embalmer No. 3506
P. O. Address K C 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.

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3332

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Manassas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3215 Campbell, conv. Home
(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 _____ (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 William P. Love

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ if less than one day _____ 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 _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-8-45 (b) Geraldine Holmes (Date received local registrar) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 7 Year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from June 27 to July 7, 1945
that I last saw him alive on July 5 and that death occurred on the date and hour stated above.

Immediate cause of death: myocarditis (n.m.o.) Duration _____

Due to _____

Due to stomach ulcers n.m.o.

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

Major findings: Of operations 117a

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)

(b) 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 Mary J. Sover (M. D. or other) _____

Address 4116 Walnut Date signed 8-8-45

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

SUPPLEMENTARY

MOTHER FATHER

26501