

**FILED** OCT 24 1945

Primary Registration District No. **1000**

Registrar's No. **960**

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Flannigan Nursing Home 2018 Francis  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20 days  
In this community 20 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town DeKalb, Missouri  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emma E. Lovelace

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife William S. Lovelace 6. (c) Age of husband or wife if alive 81 years  
7. Birth date of deceased July 25 1864  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>1</u>	<u>11</u>	hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Aaror Easter  
13. Birthplace unknown Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Nancy Snyder  
15. Birthplace unknown Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. S. Lovelace

(b) Address DeKalb, Mo.

17. (a) burial (b) Date thereof 9/9/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Westlawn Cemetery

18. (a) Signature of funeral director Walter Beale & Co. Bowman

(b) Address 319 South 10th

19. (a) 9/8/45 (b) J. H. Hestrich  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6th  
year 1945 hour 10 minute 30P M.

21. I hereby certify that I attended the deceased from Aug 17  
1945 to Sept 6 1945  
that I last saw her alive on Sept 6 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: General Thrombosis  
Due to arteriosclerosis  
Due to senile Dementia

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: ✓  
Of operations ✓  
Of autopsy ✓

Duration  
3 hrs  
15 min  
1 hr  
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) (c) Means of injury ✓

23. Signature: Charles B. Abner (M. D. or other)  
Address: 221 Kirkpatrick Bldg 3 Date signed: 9-7-1945

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

1428

Wm. S. Lovelace

Dr. C. H. Werner  
12 Park Bldg.

**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 Guadalupe Wade

Licensed Embalmer No. 4172

P. O. Address St. Joseph

**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.