DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30952

State File No.

Registration District No. 204 Primary Registration District No. 4315 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Macon 64

(b) City or town La Plata 2
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: — 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution — (Specify whether
In this community 44 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 64

(c) City or town La Plata 2
(If outside city or town limits, write "RURAL")

(d) Street No. — 0
(If rural, give location)

(e) Citizen of foreign country? Yes 0 (Yes or No)

If yes, name country England

3. (a) PRINT FULL NAME Herman Loveridge

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex M O

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 21 (Day) 1854 (Year)

8. AGE: Years 90 Months 8 Days 23 If less than one day hr. min.

9. Birthplace England (City, town, or county) 4 (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name James Loveridge
13. Birthplace England (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Harriet Hector
15. Birthplace England (City, town, or county) 11 (State or foreign country)

16. (a) Informant Marguerite Stevens
(b) Address La Plata Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 (Month) 5 (Day) 1945 (Year)
(c) Place: burial or cremation Alexis Ill

18. (a) Signature of funeral director D. S. Christie
(b) Address La Plata Mo

19. (a) Sept 4-45 (Date received local registrar) (b) H. M. Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2"
year 1945 hour 1 P.M. minute M.

21. I hereby certify that I attended the deceased from Nov. 10, 1944 to Sept. 2, 1945
that I last saw him alive on Sept. 2, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	
Chronic Interstitial	
Due to Nephritis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

131

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 C. H. Buckley (M.D. ~~or other~~)
Address La Plata Mo. Date signed 9-4-45

1390

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-45-1464
Date Filed SEP-19-1945

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 D. S. Christie

Licensed Embalmer No. 1109

P. O. Address La Plata 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.