

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 762

Primary Registration District No. 5595

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Jefferson Rock
(b) City or town Arnold
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Arnold Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none (Specify whether
4 Years
In this community 4 Years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson 50
(c) City or town Arnold
(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 Lovie Claretta Tate
FULL NAME

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

4. Sex F / 5. Color or race W.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife. Jud L. Tate
6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased May 2 1900
(Month) (Day) (Year)

8. AGE: Years 45 Months 6 Days 6
If less than one day
hr. min.

9. Birthplace Batesville Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

12. Name John S. Nichols

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

14. Maiden name Anna Sawyer

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

16. (a) Informant Jud L. Tate
(b) Address Arnold Mo.

17. (a) Burial (b) Date thereof 11/9/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cem.

18. (a) Signature of funeral director U. W. McLaughlin
(b) Address 2301 Lafayette Ave.

19. (a) Nov 9 1945 (b) Phil G. Trink
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 8
year 1945 hour 2 minute 30P. M.

21. I hereby certify that I attended the deceased from Oct 1944 to Nov 8 1945
that I last saw her alive on Nov 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma (General)
Primary left Breast
Due to.....

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

Major findings:
Of operations 50
Of autopsy.....

Duration
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 Office (Specify type of place) (a) Means of injury no

23. Signature O. Reich (M. D. or other) no
Address Hammersick Date signed 11/9/45

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

VI
0

1457

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 12-6-45

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 *O. W. Cooper*

Licensed Embalmer No. 3890

P. O. Address 2301 Lafayette

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.