

FILED AUG 12 1946

Registration District No. 17

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St. Louis County  
(b) City or town Clayton, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis Co. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 mo. 10 days  
(Specify whether years, months or days)  
In this community 12 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis Co.  
(c) City or town Robertson, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) 1  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

BLANCH LOVELL

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race C

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

6. (b) Name of husband or wife Delpha Barry

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased 5 11 19  
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 19  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Marthasville Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Operated Soft Drink Stand

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

12. Name Lyncefn Lovell

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

14. Maiden name Nona Callaway

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

16. (a) Informant Lucia Lovell

(b) Address 215 710 St. Robertson

17. (a) Burial (b) Date thereof 8-2-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem - St. Charles Mo.

18. (a) Signature of funeral director H.C. Dalbey & Sons Co.

(b) Address 800 N. 4th St. St. Charles Mo.

19. (a) 8-5-46 (b) Wm. Sarney M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30  
year 1946 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 20, 1946, to July 30, 1946;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Generalized arteriosclerosis with terminal pneumonia  
Duration 1 day

Due to \_\_\_\_\_  
Due to \_\_\_\_\_ 97

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

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: Generalized arteriosclerosis Rt. lower lobar pneumonia  
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)  
(e) Means of injury \_\_\_\_\_

23. Signature H. Zacht M.D. (M. D. or other)  
Address 601 B. S. Wood St. St. Louis Date signed 7/30/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
23619

**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.....

*Joseph F. Landolt*

Licensed Embalmer No..... *4189*

P. O. Address.....

**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.**