FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 18 1948

Registration District No. .....

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3000

State File No. 25324

Registrar's No. 205

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Comm. Nur. Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5½ months (Specify whether
In this community " " years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. Comm. N. Home
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Eva Loveland

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife DK

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

7. Birth date of deceased Dec. 9 (Month) 1878 (Day) (Year)

8. AGE: Years 69 Months 7 Days 30 If less than one day ..... hr. ..... min.

9. Birthplace DK (City, town, or county) Ill (State or foreign country)

10. Usual occupation ✓ Housewife

11. Industry or business ✓

FATHER
12. Name Sam Steele
13. Birthplace DK (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Viola Berns
15. Birthplace DK (City, town, or county) Germany (State or foreign country)

16. (a) Informant Minnie Bohlen
(b) Address Urbana, Ill

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-48 (Month) (Day) (Year)
(c) Place: burial or cremation Hopper Ill

18. (a) Signature of funeral director Dauer Funeral Home
(b) Address Kirksville Mo

19. (a) 8-8-48 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8 year 1948 hour 8 minute 48 P M.

21. I hereby certify that I attended the deceased from Feb 27, 1948, to Aug 8, 1948; that I last saw her alive on Aug 8, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Sepsis	3 days
Due to: Decubitus Ulcers	6 months
Due to: Paraplegia	16 Mo
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 83 P
Of autopsy

PHYSICIAN
Underline the cause of 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 M. T. Gutenrohr (M.D. or other) DO
Address Kirksville, Mo Date signed 8-9-49

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number 8 : 48 : 1
Date Filed AUG 1 7 1948

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 Clarence M. Bill

Licensed Embalmer No. 4375

P. O. Address Kirksville, 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.