

FILED FEB 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5759

BIRTH NO. _____		REG. DIST. NO. 278		PRIMARY REG. DIST. NO. 5953		Registrar's No. 13				
1. PLACE OF DEATH a. COUNTY Pike				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Pike						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN R.F.D. #1, Buffalo		c. LENGTH OF STAY (In this place) /		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Buffalo		9 2 3				
d. FULL NAME OF HOSPITAL OR INSTITUTION Louisiana, Mo. R.F.D. #1				d. STREET ADDRESS (If rural, give location) R.F.D. #1						
3. NAME OF DECEASED (Type or Print) Jacob			a. (First)		b. (Middle) --		c. (Last) Love			
4. DATE OF DEATH Feb. 6, 1949		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 2, 1868		9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Days 4		
5. SEX Male		6. COLOR OR RACE White		11. BIRTHPLACE (State or foreign country) Pike County, Mo.		12. CITIZEN OF WHAT COUNTRY? --		13. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming			10b. KIND OF BUSINESS OR INDUSTRY Farm			11. BIRTHPLACE (State or foreign country) Pike County, Mo.			12. CITIZEN OF WHAT COUNTRY? --	
13a. FATHER'S NAME James Love			13b. MOTHER'S MAIDEN NAME Lurinda McMillen			14. NAME OF HUSBAND OR WIFE Bell Love				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. -----			17. INFORMANT'S SIGNATURE OR NAME Mrs. Jacob Love, R.F.D. #1, Louisiana, Mo.			ADDRESS Louisiana, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH		
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastro-intestinal hemorrhage						2 to 4 days		
		ANTECEDENT CAUSES								
		*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.								
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.								
		DUE TO (b) Cerebral hemorrhage								
		DUE TO (c) Generalized Arteriosclerosis						yrs.		
		II. OTHER SIGNIFICANT CONDITIONS								
		Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?						
22. I hereby certify that I attended the deceased from _____, 1947, to _____, 1949, that I last saw the deceased alive on _____, 1949, and that death occurred at _____, from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) Chas. H. Lewellen M.D.				23b. ADDRESS Louisiana, Mo.				23c. DATE SIGNED 2-9-49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/9/49		24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		24d. LOCATION (City, town, or county) (State) Louisiana, Mo.				
DATE REC'D BY LOCAL REG. Feb 9, 1949		REGISTRAR'S SIGNATURE Bernice Collier		25. FUNERAL DIRECTOR'S SIGNATURE George O. Wagner		ADDRESS Louisiana, Mo.				

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

829

RECEIVED  
District Health Officer No. 10  
District File Number 249-331  
Date Filed FEB 9 1949

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 \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*George O. Wagner*  
Student Embalmer No. \_\_\_\_\_  
Licensed Embalmer No. 3773

P. O. Address

*Louisiana, 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.