

FILED MAR 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5344**

BIRTH NO. _____ REG. DIST. NO. **187** PRIMARY REG. DIST. NO. **3040** Registrar's No. **39**

1. PLACE OF DEATH a. COUNTY LIVINGSTON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY LIVINGSTON	
b. CITY (If outside corporate limits, write RURAL and give town) Chillicothe		c. CITY (If outside corporate limits, write RURAL and give township) CHULA	
c. LENGTH OF STAY (In this place) 5 DAYS		d. STREET ADDRESS (If rural, give location) U	
d. FULL NAME OF HOSPITAL OR INSTITUTION 307 vine st.			

3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) CLDY c. (Last) LOOMIS			4. DATE OF DEATH (Month) (Day) (Year) 2 23 1950		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 7-25-1865	9. AGE (In years last birthday) 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) Not known MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME ORAN LOOMIS	13b. MOTHER'S MAIDEN NAME LOUISA MILLEY	14. NAME OF HUSBAND OR WIFE FLOYANCE FLOUDA LOOMIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) MO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME Miss George C Loomis ADDRESS _____

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 wks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. DUE TO (b) Thromboangitis obliterans DUE TO (c) Arteriosclerosis		3 yrs.
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		3+ years

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)	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 **Jan. 1948** to **23 Feb. 1950**, that I last saw the deceased alive on **23 Feb. 1950**, and that death occurred at **6:30 pm.**, from the causes and on the date stated above.

23a. SIGNATURE Charles M. Grace (Degree or title) M.D.	23b. ADDRESS Chillicothe, Mo.	23c. DATE SIGNED 24 Feb 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 25, 1950	24c. NAME OF CEMETERY OR CREMATORY Plauvein Cemetery	24d. LOCATION (City, town, or county) (State) Chula, Mo.
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DATE REC'D BY LOCAL REG. Feb-24-50	REGISTRAR'S SIGNATURE Frances B Neill	25. FUNERAL DIRECTOR'S SIGNATURE E J Robertson ADDRESS Funeral Home, Chula, Mo.
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(Licensed Embalmers' Statement on Reverse Side)

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

597



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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed E. J. Bahertson

Licensed Embalmer No. 2448

P. O. Address Farado 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.