

No. 300
10-48

FILED OCT 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35977

State File No.

BIRTH NO. _____ REG. DIST. NO. 364 PRIMARY REG. DIST. NO. 6237 Registrar's No. 11

1. PLACE OF DEATH
a. COUNTY Warren
b. CITY (If outside corporate limits, write RURAL and give township) Rural Hickory-Grove
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Warren
c. CITY (If outside corporate limits, write RURAL and give township) Rural Hickory-Grove
d. STREET ADDRESS (If rural, give location) South Of Wright City

3. NAME OF DECEASED
a. (First) Clyde b. (Middle) Edwin c. (Last) Loveland
4. DATE OF DEATH (Month) Oct (Day) 5 (Year) 1950

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan 15 1893 9. AGE (In years last birthday) 57 IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dentist
10b. KIND OF BUSINESS OR INDUSTRY In the Office
11. BIRTHPLACE (State or foreign country) Rockford Ill
12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Gilbert Loveland 13b. MOTHER'S MAIDEN NAME Hattie Richardson 14. NAME OF HUSBAND OR WIFE Helen Koenig Loveland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War #1
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Helen Loveland ADDRESS Wright City Mo

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) (residual of Coronary artery)
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) By self-inflicted
DUE TO (c) shot wound in head
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. with 38 Cal. revolver

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT—SUICIDE—HOMICIDE (Specify) Suicide 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 21c. (CITY, TOWN, OR TOWNSHIP) Wright City (COUNTY) Warren (STATE) Mo

21d. TIME OF INJURY (Month) Oct (Day) 5 (Year) 1950 (Hour) 8 AM. 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8 A m., from the causes and on the date stated above.

23a. SIGNATURE D. F. K. Koenig (Degree or title) Coroner 23b. ADDRESS Warren Mo 23c. DATE SIGNED Oct 5

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Oct 7 1950 24c. NAME OF CEMETERY OR CREMATORY Oak-Grove Cemetery 24d. LOCATION (City, town, or county) (State) St Louis Co Mo

DATE REC'D BY LOCAL REG. 10-14-50 REGISTRAR'S SIGNATURE Mrs F-W-Hughes 25. FUNERAL DIRECTOR'S SIGNATURE Nielburg Furn & Und Co ADDRESS Wright City Mo

(Licensed Embalmer's Statement on Reverse Side)

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

File No. _____
DISTRICT HEALTH OFFICE No. 4

OCT 21 1950

RECEIVED

EX-100

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 _____

Julius J. Nieburg

Licensed Embalmer No. *3368*

P. O. Address *Wright City*

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.