

FILED NOV 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38768
9392
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2199	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4109 Westminister Ave		f. STREET ADDRESS (If rural, give location) 4109 Westminister Avenue	

3. NAME OF DECEASED (Type or Print) GEORGE L. LOVELACE			4. DATE OF DEATH (Month) (Day) (Year) November 3, 1950		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M /	8. DATE OF BIRTH Apr. 19, 1879	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Days 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Iron County, Missouri		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Laurel Lovelace	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Bertha
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Earl Lovelace 5420 Fletcher Av Jennings

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral hemorrhage R. DUE TO (c)		
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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 221X

22. I hereby certify that I attended the deceased from 2-6-50, 19, to 11-3-50, 19, that I last saw the deceased alive on 11-7-50, 19, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE James R. Meador, M.D.	(Degree or title)	23b. ADDRESS 45 Central, Clayton, Mo.	23c. DATE SIGNED 11-5-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-6-50	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE NOV 6 1950 J. B. Sander	25. FUNERAL DIRECTOR'S SIGNATURE McLAUGHLIN FUNERAL HOME, INC		ADDRESS 2301 Lafayette Dr

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

Dr. James R. Meador
2050 Blendon Dr

9392

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 Embalmer No.

Signed

H. J. Garris

Signed.....
Student Embalmer

Licensed Embalmer No. *3384*

P. O. Address. *A. Lewis*

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.