

FILED FEB 12 1951

THE DIVISION OF HEALTH OF THE STATE OF IOWA  
STANDARD CERTIFICATE OF DEATH

State File No. **558**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **91** PRIMARY REG. DIST. NO. **3012** Registrar's No. **10**

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

1. PLACE OF DEATH a. COUNTY <b>Clay</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Iowa</b> b. COUNTY <b>Polk</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Excelsior Springs</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Des Moines</b>	
c. LENGTH OF STAY (In this place) <b>5 Weeks</b>		8140	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>533 Elms Blv'd</b>		d. STREET ADDRESS (If rural, give location) <b>3300 Cresent Dr.</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			
a. (First) <b>ELMER</b>	b. (Middle)		c. (Last) <b>LOUCKS</b>	Month <b>Jan</b>	Day <b>22</b> Year <b>1951</b>	

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct 17, 1873</b>		9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Janessville Wis. 1</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		

13a. FATHER'S NAME <b>Geo. B. Loucks</b>		13b. MOTHER'S MAIDEN NAME <b>Adel Stone</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs Carrie Loucks</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>482-10-0319</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Carrie Loucks-Des Moines Iowa</b>			
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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) <b>Coronary Occlusion</b>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			DUE TO (b) _____
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____			DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					4201

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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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	
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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 **2: p m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>D. Pate M.D. Coroner</b>		23b. ADDRESS <b>North Kansas City, Mo</b>	23c. DATE SIGNED <b>1/24/51</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1-25* 1951</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Glendale Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Des Moines Iowa</b>
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DATE REC'D BY LOCAL REG. <b>1/25/51</b>	REGISTRAR'S SIGNATURE <b>Caroline Hutchings</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Hope Funeral Home - Exc. Springs Mo</b>	ADDRESS <b>Exc. Springs Mo</b>
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FEB 2 1955

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.....

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working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed *James G. Moles*

Licensed Embalmer No. 3296 Ex. Spring

P. O. Address Excelsior Springs M

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.