

FILED AUG 30 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25490

State File No.

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 223

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton, Mo.</u>		c. LENGTH OF STAY (In this place) <u>25y-6M-8D</u>	c. CITY OR TOWN <u>D.K.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #1, Fulton, Mo</u>			e. STREET ADDRESS (If rural, give location) <u>none</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>EMORY</u> b. (Middle) <u>T.</u> c. (Last) <u>LOVEFALL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 19, 1955</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1889</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>D.K. America</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>D.K.</u>		13b. MOTHER'S MAIDEN NAME <u>D.K.</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>D.K.</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Records of State Hospital #1, Fulton, Mo.</u>		ADDRESS <u>Records of State Hospital #1, Fulton, Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Mental Deficient.</u>		

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>4200.</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	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) <u>none</u>	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. 1, 1955, to Aug. 18, 1955, that I last saw the deceased alive on Aug. 18, 1955, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Wm. J. Shemes</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>State Hospital #1, Fulton, Mo.</u>	23c. DATE SIGNED <u>Aug-19-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>8-23-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>State Hosp no 1</u>	24d. LOCATION (City, town, or county) (State) <u>Fulton, Mo</u>
DATE REC'D BY LOCAL REG <u>Aug 24 1955</u>	REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>	426-	25. FUNERAL DIRECTOR'S SIGNATURE <u>C.C. Weeks - Fulton, Mo</u>

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

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.