

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007865
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 570

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>4336 UNIVERSITY CITY 0</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hosp. 1 DAY</u> Length of stay in lb | | d. STREET ADDRESS (If outside, give location) <u>6600 WASHINGTON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>Love</u> Last <u>Love</u> | | | 4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1959</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN. 1, 1882</u> |
| 9. AGE (In years last birthday) <u>77</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | 11. BIRTHPLACE (City and state or country) <u>PETERSBURG, ILL.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13a. FATHER'S NAME <u>JAMES MAXWELL LOVE</u> | | 13b. MOTHER'S MAIDEN NAME <u>ELLEN OMUN</u> | 14. NAME OF HUSBAND OR WIFE <u>NONE</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT Address <u>MRS. MARIE J. SPRAGUE, 6600 WASHINGTON</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u> | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE <u> </u> | |
| 21. I attended the deceased from Death occurred at <u>9:14</u> on <u>3-1-59</u> to <u>3-1-59</u> and last saw her alive on <u>3-1-59</u> at <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Angelo A. Spens MD</u> | | 22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u> | |
| 22c. DATE SIGNED <u>3/2/59</u> | | 22d. PLACE SIGNED <u> </u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>3-3-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LAUREL HILL GARDENS</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>ALBERT H. Hoppe, 4700 WASHINGTON</u> | | 25. DATE RECD. BY LOCAL REG. <u>3-2-59</u> | 26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Sam W. Wickham*

Licensed Embalmer No. *3575*

P. O. Address *St Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.