Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008496
STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 335

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Joseph Hosp. — Length of stay in Hospital 43yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) Rt #6 — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Alta Middle Leota Last Lovewell

4. DATE OF DEATH Month March Day 31 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH July 3, 1906
9. AGE (In years last birthday) 52 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Red Willow Co, Nebr.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME ? Fox
13b. MOTHER'S MAIDEN NAME Latricia Cox
14. NAME OF HUSBAND OR WIFE Thomas W. Lovewell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Thomas W Lovewell — Address St. Joseph, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive disease + Carcinomatosis — 1 year
DUE TO (c) Primary carcinoma of cervix — 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 171X
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3/24/59, to 3/31/59 and last saw her alive on 3/31/59
Death occurred at 10:10 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Donald J. Stallard, M.D. (Degree or title)
22b. ADDRESS 902 Edmond St
22c. DATE SIGNED 4/1/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4/3/59
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State) St. Joseph, Mo

24. FUNERAL DIRECTOR John E. Kupp — ADDRESS St. Joseph, Mo
25. DATE RECD. BY LOCAL REG. April 2, 1959
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Donald J. Stallard

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. 3986

P. O. Address St. Joseph, .

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.