

Health, Welfare & Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010643

STATE FILE NUMBER

FILED APR 1 1959

Registration District No. 316 Primary Registration District No. 4462 Registrar's No. 117

300  
1-57

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. FRANCOIS</b>                              |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. FRANCOIS</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ELIENS</b> |  | c. CITY OR TOWN <b>ELIENS</b> <sup>0940</sup>   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION     |  | d. STREET ADDRESS (If outside, give location)   |  |
| Length of stay in lb  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |

|   |                                  |   |   |  |  |
|---|----------------------------------|---|---|--|--|
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>BETTIE D. LOUVOAN</b>                            |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>FEB 24, 1959</b>               |  |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUG 13, 1872</b>                                 | 9. AGE (In years last birthday)<br><b>86</b> | FUNDED 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>ELIENS GROVE, ILL.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>              |

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|---|--|--|
| 13a. FATHER'S NAME<br><b>WILLIAM PARKER</b> | 13b. MOTHER'S MAIDEN NAME<br><b>MALINDA PARKER</b> | 14. NAME OF HUSBAND OR WIFE<br><b>ALYSES LOUVOAN</b> |
|---|--|--|

|  |  |   |         |
|--|--|---|---------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> | 16. SOCIAL SECURITY NO.<br><b>NONE</b> | 17. INFORMANT<br><b>Grandmother Eliens, Mo.</b> | Address |
|--|--|---|---------|

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|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4.200</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arterio Sclerosis</b><br>DUE TO (c)                         |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                       |  |  |

|   |  |   |
|---|--|---|
| 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.) |   |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>Month, Day, Year   |  |   |
| 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.)     | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |

21. I attended the deceased from **Jan 14 59** to **Feb 24 59** and last saw her/him/live on **Feb 16 59**  
Death occurred at **5 PM Feb 24 59** m on the date stated above; and to the best of my knowledge, from the causes stated.

|  |                   |                                      |                                    |
|--|-------------------|--------------------------------------|------------------------------------|
| 22a. SIGNATURE<br><b>C H Appleberry MD</b> | (Degree or title) | 22b. ADDRESS<br><b>Overmoines MO</b> | 22c. DATE SIGNED<br><b>2-27-59</b> |
|--|-------------------|--------------------------------------|------------------------------------|

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, or other disposal<br><b>BURIAL</b> | 23b. DATE<br><b>Feb. 27, 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKVIEW</b> | 23d. LOCATION (City, town, or county) (State)<br><b>near FARMINGTON, MO</b> |
|--|-----------------------------------|---|---|

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 24. FUNERAL DIRECTOR<br><b>Raymond Caldwell</b> | ADDRESS<br><b>Flat 212, 1459</b> | 25. DATE RECD. BY LOCAL REG.<br><b>Mar. 23, 1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>Ether Rudloff</b> |
|---|----------------------------------|--|---|

(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

MEDICAL CERTIFICATION

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 *R. Caldwell* .....

Licensed Embalmer No. *2531*  
P. O. Address *Flat River*

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.